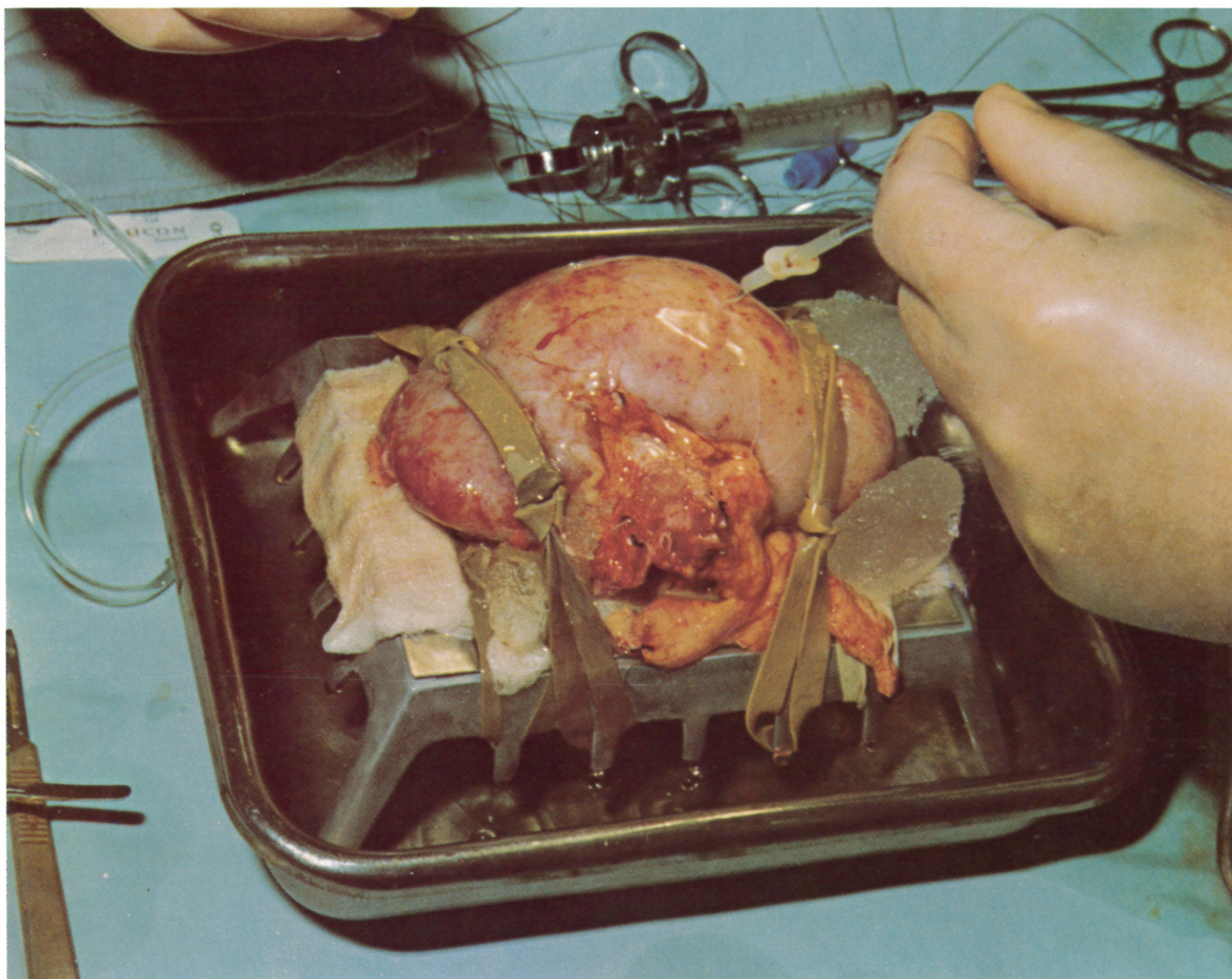




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Surgeon General

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The continued support of the Media Division, Educational Programs Development Dept., Health Sciences Education & Training Command (HSETC), NNMC, Bethesda, Md., is gratefully acknowledged.



from the Chief

NAVREGMEDCEN CAMP PENDLETON, CALIF.—Navy Surgeon General VADM D.L. Custis, MC, USN (left) and CAPT E.D. Loweecey, MC, USN (right), CO, cut the ribbon at the dedication ceremony on 1 Nov 1974, when the old naval hospital was replaced by a modern, 9-story, 600-bed facility.

Inflation is currently one of the nation's major problems. For Navy medicine and dentistry, the impact of rising costs and rising prices is compounded by a reduction in funded resources. This means, simply, that we in Navy medicine and dentistry must intensify every conceivable effort in order to achieve a Medical Department-wide objective, to *continue providing quality care to all of our eligible beneficiaries while maintaining the same, or a decreased level of resources.*

A tough objective? You bet.

Can we achieve it? I think so.

What are the alternatives? None. Either Navy medicine/dentistry will cost-effectively deliver health care, or some other organization(s) will attempt to do it, albeit at increased costs to the Navy. Achieving this objective will not be an easy task — it will demand the very best that Navy health-care management can offer. It will require broad, new thinking and decisive action by medical/dental staffs, and by those responsible for health-care administration and management. It will take complete dedication and positive involvement of every member of the Medical Department.

Alexander Graham Bell once said, "Leave the beaten track occasionally and dive into the woods." That advice is appropriate for the Navy

Medical Department today, particularly if our beaten paths consistently fail to lead to our objective. The traditional approaches to health-care delivery and the administration of our system have held us in good stead in the past. Some of these approaches remain effective today. On the other hand, if we take a close look, we may find that procedures and practices which were right for the last several decades are, for the 1970s, inefficient and wasteful in terms of resources, time, and effectiveness. Every member of the Medical Department, particularly those of you in leadership positions with management responsibilities, must adopt the premise that "there is a better way to do it," and direct the thrust of your efforts to finding that way.

As an example, the Naval Regional Medical Center (NRMC) Oakland adopted this premise when it looked into the old Navy watch system. As a result of its study, leaving the beaten track, the Medical Center successfully developed and tested a flexible enlisted workweek (BUMED Talking Paper No. 33 addresses this subject). The NRMC Oakland also conducted a comprehensive review and analysis of the medical transcription system, to determine the source of a large and growing backlog of delinquent medical dictation. As a result of the subsequent corrective action taken, the Oakland Center now provides a 24-hour turnaround of all dictated material, with expanded dictation capabilities for a greater number of departments and services.

These represent just two examples of positive proof that "there is a better way to do it," and that the way can be found if we are willing to leave the beaten track.

The objective, as defined in the first paragraph above, can and must be accomplished. Faced with the challenge of inflation, reduced resources, and outside threats, we have no alternative. In the final analysis our success will depend on the leadership, imagination, and dedication of each member of the Medical Department. As we start this new year, I am confident that all of us together can do the job.

Have a good year!



THE SURGEON GENERAL'S Sixth Annual SPECIALTIES ADVISORY CONFERENCE and COMMITTEES' MEETING

SECOND PLENARY SESSION, 18 SEP 1974

*Administrative Announcements —
CAPT S. Barchet, MC, USN:**

Good morning, gentlemen. The 2nd plenary session is off and running. Before introducing CAPT William Cox, who will present some important details pertaining to the Health Sciences Education and Training Command, I will make a few announcements.

As always, Code 316 has met its deadline. We have published and distributed the rank order list resulting from evaluation of 420 medical student applications by the Intern Program directors, the 5 Family Practice Program directors, and some BUMED representatives. This rank order list gives the names of the students from the highest score, down to the lowest score. Beside each name, up to 3 of the program preferences are listed by specialty, for each student; whether the

specialty program request was for a categorical, a categorical diversified, or a flexible year is also indicated.

I'd also like to add some information which I'll read from the Intern Guidelines, page 4: "Rank order lists will be distributed at SAC-6 by 18 Sep. Any intern or specialty director who disagrees with the scoring or the rank order that he sees must provide to us written information as to special interest, and a request for correction of the score no later than the close of business on 19 Sep." Then, on page 8 — and I want to emphasize this — item 4 states: "Finally, during BUMED's deliberations as to the placement of the rank-evaluated medical students, considerable attention will be given to a balanced student talent at each of our multispecialty and family practice graduate training academic health centers." On page 4 of the SAC Guidelines it also states: "Further, no assignments of graduating medical students are to be made. This is a BUMED prerogative."

This afternoon, the Intern Program directors and the Family Practice Program directors will meet with CAPT McDermott, CAPT McMahon, and me. If you have any questions at that time regarding these lists which you will want to take back to the hospital representatives in the committees, I'm sure we can discuss and resolve the problems with very little difficulty.

At this time, I'm extremely pleased to present CAPT William Cox, CO of the Health Sciences Education and Training Command (HSETC).

*Head, Training Branch, BUMED Code 316 and Moderator for SAC SIX.

This conference was held 16-20 Sep 1974 at Stouffer's National Center Inn, 2399 Jefferson Davis Highway, Arlington, Va. The First Plenary Session was reported in the December 1974 issue.

The above account of this annual session represents an edited (sometimes paraphrased and/or abbreviated) version of the remarks and presentations of specified individuals. Their comments do not necessarily reflect official views of the Navy Department, or the naval service at large.

"HSET Command: Functions, Activities, Responsibilities" —

*CAPT J.W. Cox, MC, USN: **

Admiral Osborne, distinguished flag officers and guests, our colleagues from sister services, chiefs of service, and shipmates. My intention this morning is to introduce to those of you who do not know what the new Health Sciences Education and Training Command (HSETC) is all about, and to those of you who worked so hard on the Single Education and Training Command Planning Board, some of the hopes, aspirations, and charges that have been passed to this new organization.

When we moved into Towers 17, 18, and half of 16 at the National Naval Medical Center, Bethesda, Md., with the fledgling staff of the new command, we adopted as a theme song "Nearer My God to Thee," and took our oxygen masks with us in the truck each morning. It didn't take very long for the command to become generally known as "H.S. et cetera."

Since World War II, the scope and size of the Navy Medical Department has grown steadily. In addition to active-duty members of the Navy and Marine Corps, the commitments of Navy medicine include the care of service dependents, a massive group of retired individuals, and some veterans. As you know, there has been a dramatic increase in sophisticated innovations in the health sciences. There have been technologic advances throughout the Navy, and the scope of Medical Department activities has increased in all phases of health services, especially in preventive medicine.

Within the Medical Department itself, education and training programs have grown piecemeal in response to operational requirements, the needs of the Medical Department itself, and the changing health-care practices of the nation. This growth has resulted in fragmented, decentralized, and often poorly identified education and training efforts. Coordinated planning for the future has been difficult, and at times inadequate. In 1969, RADM Rupnik asked me to assist him, in cooperation with Code 3 and the corps directors, to develop a BUMED organization which would provide: (1) centralized control of budget defense and budget allocation; and (2) a lattice of cooperation with specific training agents in each of the corps, working through what evolved from the head of the education and training branch as Code 316 for Medical Corps officers, to a concept of the special assistant to the assistant chief for personnel and professional operations (Code 3), and a special assistant to the Surgeon General, at that echelon. The staff of that organization



THE HSETC.—CAPT William Cox, MC, USN, commander of the HSETC, defines its mission, responsibilities, and interrelationships.

could consist of 3 individuals or, as is so often necessary, some people have to wear 2 hats and others have to be treble hatted. The point is, through the efforts of RADM Rupnik with me as his successor, CAPT Mel Museles following me, and then CAPT Steve Barchet following Mel, a rather effective BUMED education and training establishment has emerged.

But the policy that was enunciated would then pass to the echelon-3 command in the field, where it would be variously interpreted and variously perverted. There was no way for individuals from the Naval Medical Training Institute, who had the responsibility for curriculum standardization and coordination, to do anything but plead and persuade.

In addition to this absence of standardization, there are external constraining and driving forces exerted on this man's Navy Medical Department that are horrendous in their impact. In order to cope with these forces, and to communicate adequately with General Accounting Office auditors, the people from the Office of Management and Budget, Congressional investigating committees, and hearings on budget, it is absolutely necessary that there be a standardized procedure, and a single focal point for consistently providing accurate answers to questions that are raised regarding allocation of our funds and personnel.

*CO, HSETC, Bethesda, Md.

The mission of the new command which will serve as that focal point in the field, is to execute all BUMED policy in a programmatic sense. That is, BUMED will get out of the business of signing requisitions and sending out letters of authorization with funding data, or answering complaints as to why one did or didn't go to this or that meeting. For all the Medical Department corps, these tasks will be transferred by the approved recommendation of the Single Education and Training Command Planning Board, and will represent a 3rd-echelon function of the Health Sciences Education and Training Command (HSETC). Under the immediate direction of the Chief of the Bureau of Medicine and Surgery, the HSETC staff will implement policy and exercise control over the administration and management of health sciences education, and clinical investigation training programs for the Department of the Navy. The HSETC will be responsible for developing plans, procedures, objectives, priorities and standards to meet education and training requirements; it will also establish, evaluate and maintain optimal health science educational and training programs within available or acquirable resources, ensuring maximal responsiveness to the operational and professional needs of the Navy. In addition, the HSETC will provide budgetary support for the training activities and programs of the Navy Medical Department.

In the succeeding minutes allocated to me I will discuss the why, what, how and where of the HSETC in sufficient detail for all of you, I hope, to gain a functional perspective of the HSETC relationship to you, to BUMED, and to other organizations, both civilian and federal.

It is the responsibility of the HSETC to take over the day-to-day programmatic operations so that Code 3 can get on with planning, programming, analyzing and establishing policy, objectives, and specific functions. In keeping with the specific needs of the Navy, the staff of the HSETC will:

- Plan for and provide education and training for health care personnel at the technical, undergraduate, graduate, and postdoctoral levels.
- Provide appropriate continuing education programs for all Medical Department personnel.
- Evaluate and audit health sciences education and training programs.
- Provide support for educational counseling services for Medical Department personnel.
- Develop and maintain media services for education and training throughout the Medical Department establishment.
- Establish, maintain, coordinate, and support funding

requirements for subordinate commands in the Clinical Investigation Program.

► Develop adequate staffing requirements and advise BUMED on the criteria for faculty stability, as well as administrative and teaching support.

► Insure that programs are provided for orientation and indoctrination of Medical Department personnel.

Organizational relationships of the HSETC are portrayed in Figure 1, leading by echelon from the Office of the Chief of Naval Operations, to the Surgeon General in BUMED, to the 3rd-echelon Medical Department commands, and finally to the 4th-echelon, subordinate commands that are involved. I think it's important that, for purposes of reporting and access to BUMED, the commanding officer of the Naval Graduate Dental School (NGDS) and the commanding officers of the regional medical centers (RMCs) have direct access on all matters under their purview. But in matters relating to the execution of policy for the conduct of education and training programs, liaison through additional duty lines will be maintained between the Corps program directors in the headquarters command of HSETC, and both the RMCs and the NGDS. This will become clearer as we discuss the relationship of the HSETC to BUMED, and the prototypal relationship of the RMCs. The HSETC liaison will foster interaction on the NGDS, the RMCs, and the "C" schools at the RMCs. (See Figure 2) The "C" schools at the Naval Aerospace Medical Institute, the Naval Undersea Medical Institute, the Naval Schools of Health Sciences at San Diego and Portsmouth, Va., and the Naval School of Health Care Administration at NNMC Bethesda, are directly under the HSETC; but in an organization with a primary mission that is other than education and training (for instance, Oakland), the "C" schools will still remain in the command line, under the regional medical center commander. Under the authority of the Chief of BUMED,

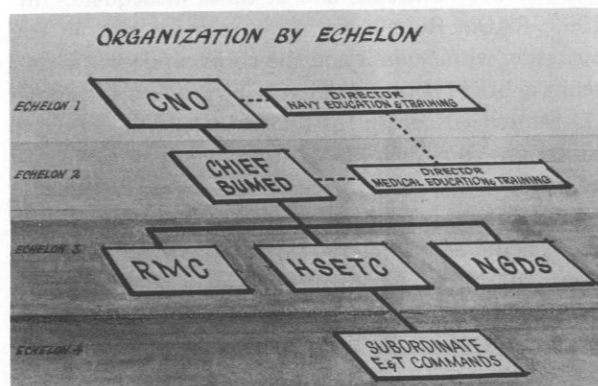


Figure 1.—Schematic diagram of the HSETC organizational relationships.

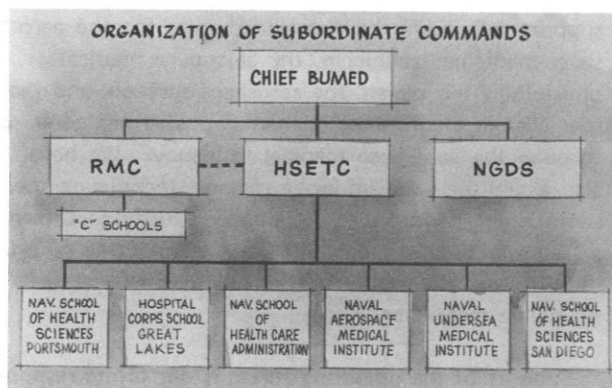


Figure 2.

responsibility for budget support, instructor billets, curriculum standards, audit, and academic boards for continuation, probation, or disenrollment of students, will remain with the HSETC.

The 6 blocks at the bottom of Figure 2 represent the organizations in the field, and you can appreciate the broad span of involvement. I recently made a site visit to Pensacola to look at the Naval Aerospace Medical Institute (NAMI) programs for which I am responsible, as well as a few of the nontraining ventures for which NAMI is responsible. The Thousand Aviator Study is being conducted there, and the follow-up evaluation of all repatriated former prisoners of war from the naval aviation community. NAMI personnel also perform all of the physical examinations for flight candidates, and a special board of flight examiners is situated at the Institute. The entire hearing-conservation program for the Navy is concentrated in an organization which is intrinsic to NAMI. Obviously there must be an exceedingly close relationship between the commanding officer of NAMI and the commanding officer of the Regional and Aerospace Medical Center. A similar case can be made for the Naval Undersea Medical Institute. And, at San Diego, cooperation between the dental "A" and "C" schools, and the Naval School of Health Sciences is most important. In its new building at Great Lakes, the Hospital Corps School is responsible for the "A" school, and it will also acquire responsibility for the "C" school training of certain, selected, technician and technologist-training programs.

In Figure 3 the organization structure, and the relationships of education and training in RMCs are graphically presented. The Education and Training Committee, and the Graduate Education and Training Committee can be two separate organizations in the large RMCs; but smaller centers may have 1 combined committee, with 2 subcommittees for specific considerations. The Graduate Education Committee will keep

the commanding officer informed of all deliberations pertaining to graduate trainees in the medical and dental fields, whereas, the chairman of the Education and Training Committee will be concerned with the education and training of other corps communities, including all advanced enlisted schools, continuing education, in-service training programs, team training, and Naval Reserve-Ready units that engage in drill training at a regional medical facility. The Education and Training Command Planning Board has an excellent concept wherein the committee chairmen will have additional duty under the commanding officer of the HSETC. In this way, the education and training needs of the organization can be transmitted directly to HSETC personnel, and efforts to satisfy the requirements can be initiated promptly. The direct link between the RMCs and the HSETC forms an extremely important 2-way street.

The organization of the HSETC headquarters is probably unique in naval medical organizations. As depicted in Figure 4, there are 3 major functional areas under 1 line from the office of the commanding officer; but the corps program directors — for clinical investigation, the Medical Corps, the Dental Corps, the Nurse Corps, the Medical Service Corps, and the Hospital Corps — will carry out the day-to-day, routine operation of well established policy.

However, where there are requirements and contingencies that necessitate team effort to order priorities, to identify required trade-offs, and to meet changing priorities as directed by BUMED, these persons will be organized into an Executive Council (shown as "Policy Council" in Figure 4). These personnel will meet as a responsible corporate body to develop add-ons by order of precedence, in consonance with the needs of each corps community and in keeping with the overall



Figure 3.

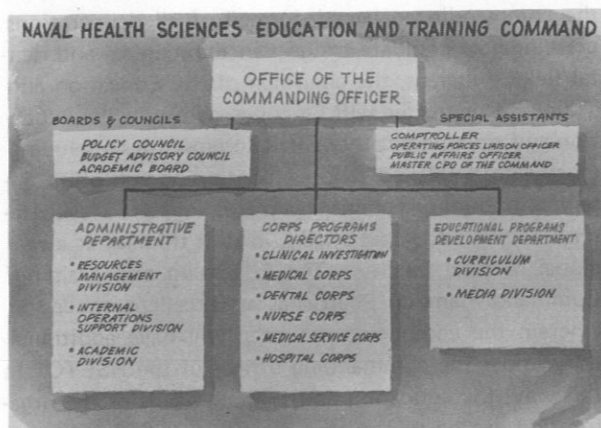


Figure 4.

requirements of the Navy Medical Department. The Executive Council will then report to me their recommendations, the available alternatives, and the pros and cons of each alternative.

The Executive Council will have the support of 2 command departments to help them meet their responsibilities to their corps communities in the 4th-echelon command and attachments, and in their relationships to the regional medical and the regional dental centers: the Educational Programs Development Department, comprised of professionals who are experts in curriculum development and in media services, including television, film, exhibits, illustrations, and the still photo lab; and the Administrative Department, with its resources-management system. This department will review education and training budget submissions, and will manage the accounting system for maintaining background data, such as the number of students on board for how many days, with further breakdown by geographic location, specialty, or training program; it will also have the necessary expertise to develop a 3-dimensional, cost-accounting system, providing reliable information for justification of projected needs and requirements. Also within this department is an academic division that operates the schools which are located at the National Naval Medical Center in Bethesda.

I've already alluded to the role of the Executive Council. The other special assistants are not unique to the command, nor are the other councils.

You are familiar with the graduate education of physicians and dentists, and you all know about nursing; but what about the 26,000 young men and women who support our systems, especially those in operational

support roles? We have provided roles for the aerospace-medicine technician, the aerospace medical-physiologic technician, the aerospace surgeon, and the specialist in environmental medicine who has gone through the aerospace medical residency. We have also established the undersea medical technician, the submarine technician, the independent duty corpsmen at sea and their responsibility to the undersea community, and the highly specialized field of the deep sea-diving technician.

Support of the operating forces is our prime responsibility. The number-1 priority for the support divisions in the HSETC right now is to improve the performance proficiency of our independent duty corpsmen, whether they be surface, subsurface, or air medical-service technicians. You are already familiar with the more traditional roles, such as clinical nuclear medicine, radiologic, and radiologic-assistant technicians.

What about the future? Ladies and gentlemen, I can only tell you that I had the great privilege of serving on the Single Education and Training Command Planning Board, chaired by VADM Malcolm Cagle; then he was placed in charge of the whole operation, and he had great problems putting submariners, aviators, and blackshoes from the surface Navy together. I recognize fully that I, my staff, and the people involved in BUMED have got our hands full when we try putting doctors, nurses, dentists, technicians and technologists all in bed together. The parochial interests that pervade our organization are something to behold.

Some tasks that should be simple assume the proportions and magnitude of trying to pull a redwood tree out by its roots at the Sequoia National Park. However, the Surgeon General's report has been approved; we have CNO's and SECNAV's approval to get on with this job. The line succeeded at it; many problems in education and training capability were corrected in 2 short years, and the programs have reached high levels of excellence in the 3rd year. We hope to be able to accomplish the same thing. We hope to provide a career-fulfillment pathway for all of our constituent corps members: the Medical Service Corps in allied science and health-services administration divisions, the Nurse Corps in conventional nursing roles and in the physician extender role, the Dental Corps, and last but not least, the Medical Corps. There must be no dead-end careers; mobility must be both vertical and horizontal in the career lattice; and gateways to cross over or rise to the top of any of the corps must be open to all qualified aspirants.

QUESTION AND ANSWER PERIOD

Q. How do the program directors interrelate with this new HSETC?

CAPT Cox: The program directors are in a line of command. A formal request for change in policy or change in funding would go through the Executive Council of the Graduate Training Committee. The chairman of the Executive Council will have official entry to the HSETC through additional duty orders.

In terms of your individual relationship, the Medical Corps program directors within a given command will have an interface with me, with counterparts in BUMED, and with each and every one of you. So you will really operate much the same as you're doing now. If you have a problem now, you call Bill McDermott or Steve Barchet. But they are so harassed and inundated with day-to-day operations that they can't get on with their Bureau function of planning, programming, and analyzing what we are going to do 25 years from now. So the day-to-day operations will move to the 18th floor at NNMC, and that is where Bill McDermott will be. If it's within BUMED policy, if the resources are available, and if you justify your request, we can get action for you much more quickly than in the past.

I want to emphasize that for actions which lie within BUMED policy and for which resources are available, a representative from all the Medical Department corps will be situated in the HSETC to make the necessary trade-offs, and to streamline some of the delayed staffing which now exists. We're good friends here, and we may as well point out that the present trend is to cut staffing of headquarters echelons. So HSETC at Bethesda will have more personnel to respond to your individual needs more quickly than the Bureau ever could.

Q. What's going to happen to our Medical Osteopathic Student Program (MOSP)? Will the student be selected at the Bureau, or will he send his application to HSETC and enter the selection process there?

CAPT Cox: This is an extremely important point which I did not cover in my talk. For a variety of necessary and compelling reasons, the administration of what are called "subsidy acquisition programs" will remain in the Bureau. However, there is no reason why a mechanism cannot be worked out wherein the Bureau directive will stipulate that application be made to the Bureau via the HSETC. Then all of the correspondence, the mailing of the application and collation of the letters of recommendation, can be properly formulated (and hopefully, in future years, placed in an automated data processing system); a completed record can

be passed to the Bureau for use by the selection board.

You are now in the process of assisting in the selection of graduate trainees for a regional medical center. The Bureau has done all of the paperwork, has received all of the telephone calls and has interviewed all of the students who come to Washington; but Bureau personnel simply do not have sufficient time to involve themselves in such a venture. There is no reason why applications can't be mailed out and processed, the letters of recommendation collated, and everything put in order at the 3rd echelon, or the field command, in order to take the load off of the Bureau in the future. Then the completed application and record can be forwarded to the SAC for deliberation and professional recommendation regarding the final selection.

CAPT Barchet: We cut from 250 MOSP billets down to 218, in a recent budget decrement that was absolutely necessary.

CAPT Cox: Well, for better than 3 years there has been an orchestrated effort to kill both the fully sponsored medical, and fully sponsored dental, active-duty scholarship programs. We've fought a delaying action. We changed our ground rule so that, as of last year, no one is eligible for entry into that program unless he is already in one of the active-duty communities (not limited to the Medical Department), and is eligible to enter medical school from that community, with transfer of his status (from whatever it may have been) to ENS in the 1965 program.

There is one caveat: if an individual finds that, after being a hospital corpsman or aviation electronics technician for 6 or 8 years, he has to have a year of biochemistry or some other lab course that requires a full year of study, and if the only way he can complete this course is to take off his active-duty uniform and attend a civilian institution in a full-time status on his own, if he can give a declaration of intent and make it clear why he is leaving active duty, then he is eligible for selection to MOSP and to the Dental Scholarship Student Program as a member of the Naval Reserve.

We're going to go down in numbers. Undoubtedly there will be more hearings to kill this program in the future, but we must have it; it is part of the career lattice, and I think it's one of our vital programs in an all-volunteer Navy. It can get smaller, but it must be a gateway maintained in that career lattice.

Q. Will all residency programs in each and every specialty be standardized? Is there a likelihood that HSFTC will dictate or make uniform all components of all curricula in every center, in every region, and in every area for every program?

There were lighter moments . . .



CAPT Steve Barchet, MC, USN (left), moderator of SAC-SIX, and CAPT Bill McDermott, MC, USN (right).



RADM R.W. Elliott, Jr., DC, USN (left), and RADM R. Laning, MC, USN (right).



RADM Paul Kaufman, MC, USN (left), and RADM C.L. Waite, MC, USN (right).



RADM P.O. Geib, MC, USN (3rd from the right), and table.

And touching moments . . .

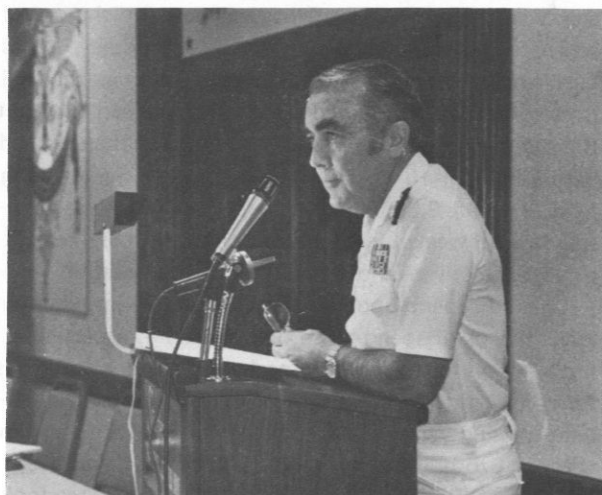


FAREWELL TO RADM G.H. REIFENSTEIN, MC, USNR (Ret.).—VADM D.L. Custis, MC, USN (left), the Navy Surgeon General presented a gift and Certificate of Merit to Dr. Reifstein for dedicated and outstanding service: as a physician; as technical director of clinical research and medical education, HSETC; and as the first director of the Clinical Investigation Program.

And telling moments



PRESIDENT OF THE AMERICAN MEDICAL SOCIETY.—Dr. Malcolm C. Todd spoke on "National Health Policy," at the banquet held on the evening of 17 Sep 1974.



THE SURGEON GENERAL.—On "Perspectives of the Navy Medical Dept."

CAPT Cox: Let me deal with the graduate training programs for physicians and dentists. The HSETC has no intention of dictating specifications or standardizing the curricula for residency training programs, and sooner or later, for fellowships. This is the function of the Council on Graduate Medical Education of the American Medical Association. What the HSETC will do is see to it that we maintain our own internal surveillance, as Code 316 has done for many years, to assure that real education and training opportunities for participants are preserved. We will see to it that the essentials are met, and that the programs are indeed doing what they are said to be doing; but in terms of standardization and conformity to a rigid curricular content, the answer is, "no." What we will do is point out where repetitive skill tasks occur, where there are repetitive, time-consuming and expensive lectures. We will try to mediate this excess in such a way that the student can go to a regional medical center library, knowing that excellent multi-media format packages are available for use as an adjuvant, or as a supplementary aspect of the training program.

In educating technician-technologists, we will strive for maximum efficiency in training individuals to an acceptable level of proficiency, as defined by task analysis. Then, through engineering-systems design of curricula, we can hopefully come to realize economies by reducing the training time. The curriculum in the hospital "A" school, which required 16 weeks a few years ago, was reduced to 14 weeks, and now, by the use of self-paced instruction and by learning modules, it has been further condensed to 10 weeks. Although the trial isn't completed, we are confident that we can turn out the same, or a better product in 10 weeks than we did before in 14 or 16 weeks. If you consider the standing load of about 9,000 students per year for 10 weeks, instead of 16 weeks, you can calculate the cost benefit or cost effectiveness of that kind of an operation.

I would depend upon you gentlemen to eliminate the locked steps of spending so many years in a particular program, and to refine the mechanisms and innovations for accelerating accomplishment during the formal graduate training years. There has to be a certain minimum time, but to quote something that many of you heard Dr. George Reifenstein say some years back, we look forward to the day when competence is the standard and time is the variable. Unfortunately, up to the present, time has been the constant and competence has been the variable.

Q. How will the HSETC juggle 1,000 or more balls at one time, and do it equitably, effectively, and efficiently, as perceived by all program directors

everywhere? I'm talking about the fact that, in graduate medical education today, we have just over 1,000 approved professional advisory board positions for graduate medical education. We now have over 800 students on board, and we can anticipate eventually having approximately 900 or 950 physician trainees in graduate training programs. And we well know that we want to meet our requirements. Therefore, when you receive requests from, let's say internal medicine or OB/GYN for an expansion in a program, how are you going to relate that expansion to the needs of the other departments?

CAPT Cox: I understand the numbers, and the latter part of the question, but I don't understand the initial part of the question. I'll try to interpolate and give an answer.

We are embarking on an era of numerical reductions and constraints. We recognize that certain elements of our workload and responsibilities are increasing quantitatively, and that the technologic complexities in all the specialties are mounting very rapidly. We will do our best to defend, acquire, and program for increases in future resources, but when demand exceeds supply, there has to be a well considered priority list. At the present time, if one wants to go up in numbers, something else has to go down in numbers. In the future, as I see it, there have to be internal trade-offs for new programs as they come in, older programs that have served their purpose can be quantitatively diminished, or perhaps totally eliminated in some instances.

I have no intention of eliminating internal medicine. But I'm speaking of something like the Physician's Assistant training program, for example. Right now we have a planned input for 100 students per year at Sheppard Air Force Base. The Air Force requirement has implemented that Phase 1 at capacity with the Navy. Therefore, it is impossible for the Army to consolidate in Phase 1 at this time. But after the inventory of physician assistants on duty is filled in future years, depending on retention and direct acquisition considerations, we could reduce the input to that training pipeline. At that time, the Army program may consolidate with the Air Force and the Navy at a single site, for a true tri-service, cross-staffed Phase 1 program.

If our needs in internal medicine cannot be met, or if we can't afford to train an individual and there's a vacancy in one of the other services, then I think parochial attitudes are unacceptable. If a man is qualified to enter an approved graduate training program, and if he is a member of the Air Force or the Army and wants to stay in the Air Force or the Army, we must still accept him.

Introductory Remarks —

*CAPT W.M. McDermott, Jr., MC, USN: **

The future of the Navy Medical Corps, and therefore the future of our Navy's health care delivery system, depends in large part on the successful recruitment of qualified physicians. VADM Emmett H. Tidd, USN, provides full and unqualified support in this vital arena.

Directing all-out effort by the Navy Recruiting Command, VADM Tidd has come from an illustrious naval career that began as an apprentice seaman in 1942. He has held many commands in the fleet, and was twice a member of the staff in the Strategic Plans Division, Office of the Chief of Naval Operations (CNO). In 1969, VADM Tidd became chief of staff to Admiral Zumwalt (now retired), who at that time was Commander, United States Naval Forces Vietnam, and chief of the Naval Advisory Group MACV. In Jun 1970, VADM Tidd became a special assistant to the CNO and Vice CNO for Decision Coordination, Navy Department. From Aug 1971 to Mar 1972, he commanded Destroyer Flotilla 6. In Apr 1972, he became head of the Navy Recruiting Command. It is a great privilege to have VADM Tidd with us today to discuss Medical Corps recruiting.

"Medical Recruiting" —

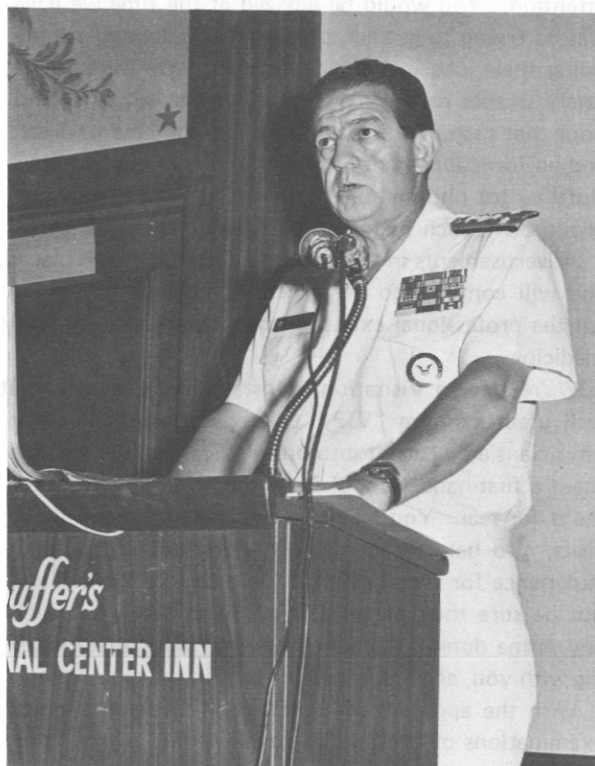
*VADM Emmett H. Tidd, USN: ***

Admiral Osborne, and many other distinguished gentlemen, ladies, and friends. It is indeed a pleasure to be with this very distinguished group of professionals. Certainly as a blackshoe I am very proud of the opportunity because I have something I want to tell you, and the big part of it is that I need your help, each and every one of you.

When I addressed this distinguished group of medical educators about 1 year ago, I had just assumed the very major challenge of recruiting for active-duty physicians. At that time, our medical recruiting program was certainly in its infancy; in fact, it was just on paper. We had begun to establish the basic recruiting organization through which we would operate in the recruitment of physicians for the all-volunteer Navy. Then, and now, the recruiting of medical officers represents one of the greatest challenges that we face in recruiting. But it can be done. Our present product is just too good to even think of it not succeeding. It's not easy but it is feasible, and we intend to succeed.

I've accepted this challenge, and I pledge to you that I'm going to use every asset at our disposal. I ask you to make the same commitment, to do your part. The paper organization is there. We've got the skeleton; we need some muscle and meat on those bones. We've undertaken a series of initiatives through which we are attempting to seek out, and to identify every possible prospective Navy medical officer. We need your help — at your activity and in your department — because each of the initiatives that I'm going to mention is somehow related to you. Our objective is that each identified prospect be given personalized attention, from the commencement of application processing until commissioning, and reporting to the first duty station. Throughout this process, you may be involved. We ask you to give personal, red-carpet treatment — the kind that you want a professional in your category to receive.

Throughout this past year, we've approached the recruiting of physicians under a total recruiting concept. Our efforts include the assignment of Medical Service Corps officers to the staff of each of our 7 recruiting-area commanders. I've assigned these fine young officers, and have watched them in action over this past year. They've developed their organization and, as the



VADM EMMETT H. TIDD, USN.—Personalized attention is essential to success in physician recruiting. "You can help us with that one-on-one contact."

*Assistant Head, Training Branch, Professional Division, BUMED Code 316-1.

**Commander, Navy Recruiting Command.

team leaders, are working the longest hours of any people in the organization. They are leaving no stone unturned in their efforts to recruit the kind of quality medical officers that you want as part of your team. They can't do it alone; each one represents the team manager, the quarterback in their location who draws upon all of the assets that are available. They've shown enthusiasm and dedication. They work under many adverse conditions that you are aware of, and are an inspiration to all of my organization.

I want to comment on our marketing approach. We are using all available media and assets. Our direct mail campaigns have been initiated to inform physicians of the opportunities that exist in Navy medicine. So far we've sent out over 100,000 direct mailings to selected lists of senior medical students, residents, interns, and young physicians in private practice. This program will continue. In the month of October, there will be more mailings to interns, residents, general practitioners, and doctors of osteopathy.

As for advertising brochures, I think we have not disseminated sufficient quantities of the quality that I want. But we do distribute material now for general medical officers, and for 8 medical specialties. These are currently being circulated.

A problem exists here that I'd like to call to your attention. You would be amazed at the time we have wasted trying to get acceptable photographs of people doing their jobs in your department. We were absolutely unable to use many photographs, and I would hope that such pictures do not reflect the kind of dress and uniform appearance ordinarily seen in our hospitals. But I've got photographic evidence of it, and I'm not proud of it; such material does you great disservice.

Advertisements in the printed media have been placed, and will continue to be placed in medical journals to get the professional exposure that is necessary for Navy medicine.

We're using a Visitation to Installations Program, that we'll use acronym "VIP," whereby prospective Navy physicians are brought into our medical facilities to give them a first-hand view of Navy medicine in action, to see it for real. You might be involved in some of these visits. Do help us to make it a pleasant professional experience for these visitors. Help us to sell the Navy, but be sure they perceive it like it is. We don't seek any prima donnas; I know you don't want them working with you, and I don't want them in the club either.

With the approval of the Surgeon General, physical examinations of prospective naval medical officers are now being conducted at naval regional medical centers. This brings the applicant into contact with Navy medicine in a positive atmosphere. We need your help here.

It's another chance to show the Navy like it is, but also to show the applicants that somebody cares, that the Navy is an organization which is people-oriented.

Each applicant is placed in contact with our detailers in BUMED to discuss possible duty assignment. Again, no miracle, just a personal approach. Each selected applicant is contacted by telephone when final action on his application has been completed, giving that personalized attention which we feel is essential to success. And it's very important to provide this kind of follow-up, particularly to the nonselectees, because they've probably been sponsored by centers of influence whose continued positive support is essential. Help us in that aspect.

We're currently utilizing active-duty retired reserve medical officers to assist us in our direct one-to-one contact with physician prospects; and believe me, this is going to be the key to success in this recruiting program. No amount of printed media, no amount of direct mail, no amount of "Madison Avenue" advertising is going to do what the one-to-one professional relationship can accomplish. We have seen this demonstrated in a very difficult program, the Nuclear Power Officer Candidate Program. Advertising won't do it; it takes one-on-one experts who know what life in the profession is like. You can help us with that one-on-one contact. This physician-to-physician relationship has proved to be our most successful method. We need more of this, and we intend to ask you for it.

I want to thank everyone who has assisted us in so many ways. Our goal for Fiscal Year 1975 is for 537 direct appointments. As you well know, those direct appointments for active duty are in the specialties so desperately needed, which are critical in the civilian community as well; we were highly competitive with the civilian world in seeking these specialists, as well as general practitioners.

We now have approximately 100 applications, plus the 111 candidates who have been selected, and an additional 110 good applications in process in the field. Our projection is that during this fiscal year, we will probably recruit and appoint about 300 to 325 physicians toward that goal of 537. This means a short-fall of about 200 physicians. We are behind the curve; we need to do better, and we can! But we will hold to quality. I don't have any desire to lower the standards of Navy medicine, and I know that you do not.

Our recruiting efforts for 1975 suffered a very major setback during the prime season of the year — June, July and August — when we were unable to get the implementing instructions approved for the Variable Incentive Pay plan. This was approved by Congress in May as you know, and signed by the President. The

subsequent delay in implementation hurt us in a prime time period. The cost to us, I think, is more than the direct loss of applications; the high cost really was the ripple effect in the centers of influence. Those individuals who were helping us to attract and convince the young physician, the young student intern, then developed doubts about whether this was another one of those things in bureaucracy upon which you cannot rely, when we couldn't tell them what the future pay was going to be even after the plan had been passed by Congress. We must restore that damaged credibility. Help us to explain that this delay was simply "one of those things" that does happen in this good country.

For good and justifiable reasons, the VIP plan was being scrutinized in the light of the new and increasing pressure of inflation on the economy. Just as the President pledged, no cows were sacred and everything had to be carefully weighed, to be sure that it could stand on its merit. I'm proud that your program did stand. The program that was approved allows, basically, for the maximum amount of money that had been recommended.

The VIP plan has now been implemented. It's not a panacea for all our problems in physician recruiting, but it certainly represents one of the greatest incentives we now have for getting our foot in the door. We can at least get the attention of physicians and show them that there is a competitive pay scale; when you consider many things together, such as an annual \$30,000, or more malpractice insurance premium in civilian life, there are some compelling assets to offer for consideration of a naval career. Not only is the VIP going to assist us in our recruiting efforts, but it is also going to help us in the retention of those quality physicians that you want to keep on the team. And believe me, I'm supporting retention because each one that you ship over means 2 to 3 that I don't have to find, for me to recruit and for you to train further. Your attention and contributions to retention represent a very active form of in-service recruiting that is most helpful to us.

I think I've made it clear that in the Navy the recruiting of physicians does not rest only with the Recruiting Command and with BUMED; every Navy medical officer must also assume a responsible recruiting role wherever, and whenever, he or she can. We need your initiative. We can't tell you how to do it; you know far better than we how to tell your story in those direct personal contacts, and why you would recommend Navy medicine to others. In relationships with your counterparts in civilian graduate medical education, and in your association with the civilian medical community, there are opportunities for you to help us sell Navy. You can tell them about the life-styles, the advantages,

and why you've stayed in. In this way you can do much to enhance the total recruiting effort.

We've gained a lot of valuable experience over this past year, and we'll continue to learn and to develop new skills in this business of recruiting physicians. The task ahead is difficult, and there's still a lot of people who say it can't be done; I don't believe it, and I've told my recruiters that they don't believe it either. We've overcome problems in some other difficult areas, and with your assistance we'll overcome these.

In our aviation officer recruiting efforts just a year ago, we were under great pressure to reduce our standards for aviation officers, to drop down from the requirement of a baccalaureate degree, to a requirement of only a 2-year college program. I told them we'd be on the curve by January; we made it by January, and we finished the year at 105% of our aviation officer recruiting. The same kind of progress is now being made in the very difficult Nuclear Officer Propulsion Program, and we're going to succeed there, too. That is why I can say with confidence that we can do it in the physician recruiting field. Our Navy has responded to many challenges like this in the past; this is just another recruiting challenge, but a very vital one. I need your help, and I ask for it.

I was most discouraged recently, in the west, to be advised by a reserve physician that many reserve medical officers were offended because they were not asked to assist with this effort. Well, I don't know what they're reading, and I don't know if we have to send them an engraved invitation; but all hands in this Navy — active, reserve, and retired — are being asked to assist. We need them to come forward. If any of them are offended that they haven't been asked, perhaps they're not listening.

The all-volunteer-force concept can succeed, I'm convinced of that. We're seeing it happen. But every citizen must help. The American public can have a zero draft if they want it, but they must do their active part by assisting in recruiting the all-volunteer force.

The pendulum of public opinion is swinging dramatically in support of the military. Just 5 months ago you may have read the results of the annual survey by the Institute of Social Research at the University of Michigan, which found this year that the military was listed as the most respected of all groups within our society, including various agencies of the Government, the schools, and the medical profession. This is a striking turnabout, just 1 year after the longest and most bitter war in our Nation's history. Of all the recent happenings, I consider the end of the draft to be one of the greatest catalysts for improving the military, and military medicine. We now have to be leaders and

managers, not dictators. We've got to use reason; we've got to have human compassion; we've got to know what a bedside manner is. This applies to blackshoes, as well as physicians.

I'm going to count on more of the wonderful assistance that we've received from you over this past year. Thank you for the opportunity to be with you this morning, and for all the future support which I anticipate.

QUESTION AND ANSWER PERIOD

Q. Admiral, it appears to me that we can benefit each other in this person-to-person recruiting approach, by utilizing the funds which you have available for travel under the recruiting program, when we can combine our motives for travel in advance.

VADM Tidd: Yes, I appreciate that; I have no problem finding people who will help me spend my money. But should you at any time see a kind of a tie-in, a chance to do "double duty," do contact our recruiting district commanding officer; we have developed into 43 recruiting districts, under those 7 recruiting areas. We can give you the name and address of the local liaison officer any time, especially when you're out in the field and you don't know how to get in touch with him. I'd be tremendously embarrassed if that local liaison officer has not contacted you, but I would also charge you with contacting him.

There is a national toll-free number that you can call to find out a lot about the Navy, and about requirements in other programs; it is 800-841-8000. At our happy hours we ask somebody to recite that phone number in a group; if he fails, he owes you the next drink. You might try using that at your banquet tonight.

Through this telephone number you can find out about any recruiting program, 24 hours a day, 7 days a week. If you want to find out who is the local recruiting district commanding officer for Los Angeles, and what his telephone number is, you can get it by calling the national toll-free number. Then contact CAPT Blackwood, tell him you are going to be at a certain convention, and offer your assistance. The area liaison officer will then probably get in contact with you. We won't be able to accept all of these offers certainly, and please try to understand that most of them will probably be turned down. I know how much physicians need that conference travel money, and some assistance can be used. We would appreciate the help in recruiting.

Q. Admiral Tidd, would you care to comment on the cooperative Recruiting Command-BUMED venture

in recruiting exhibits, and attendance at professional meetings where the exhibit has recruiting potential?

VADM Tidd: This is very important. I think we have been unsatisfactory in exhibits in the past. The BUMED (primarily contract) effort has been a good one, and I now have under my control the Navy Exhibit Center. It finally went bankrupt, and then they gave it to me. I'm very proud of the good group of dedicated people over there, and I think we'll be able to offer better exhibits in the future. It is a matter of funding; we're doing what we can, as soon as we can; but we need the kind of professional exhibits that are meaningful at your particular conferences, and I've seen some that, frankly, didn't turn me on. We welcome your ideas on innovative exhibits that are small enough to get around the country and be reused. And you can probably best tell us what will most interest interns these days.

Q. Admiral Tidd, as you can see from viewing this group, minority recruiting in the Navy Medical Corps is not too successful. What effort is your command making to improve this situation?

VADM Tidd: This is an area in which we are less successful, because we just don't have the number of minorities in internships that we want. I would particularly request that every individual make an effort to help us in this area, and I have very definitely laid down the requirement that minority recruiting not be limited to our minority recruiters. It is an all-hands problem.

At every university that we visit, we seek out the minorities who can meet our high standards. They are out there, but we are competing for them with industry which way outbids us as you well know. We must offer them an opportunity for service, for dedication, recognition, and particularly a way to help other minorities.

We are the only one of the military services with a minority advertising agency which gives us the specialized kind of material and awareness that's so necessary; and I think that in our recruiting materials, minorities are always considered in a true context, not out of proportion.

As you know, the Navy has the lowest percentage of minorities of any of the services. We're trying to correct this, but we're not going to promise something we can't deliver, and we don't want it to appear that way in the advertising.

Q. All that I've seen advertised in the usual black publications has either been slanted, or aligned toward the air part of the Navy. I haven't seen any directed toward young physicians.

VADM Tidd: That's right, because the publications that you're referring to are, more or less, general publications. Our quality minority advertising is in *Ebony*, and *Jet*, and those magazines read by young people who represent the market for enlistment, OCS, and aviation programs. In professional publications we're using tailored advertising, not slanted specifically at the minority groups. You'll notice that in some of these advertisements, minorities are included and will hopefully command attention. But our major success must be the one-on-one contact, to seek out the qualified individual and get his application in, by selling him on the Navy. So your point is correct, but it's in keeping with our intended strategy.

Introductory Remarks —

CAPT Steve Barchet, MC, USN:

Our next speaker this morning is William D. Mayer, M.D., professor, physician, educator, author, former Marine, and of late a medical executive administrator. He tells me that he is unquestionably a liberated ex-dean.

Dr. Mayer received his M.D. degree from the University of Rochester School of Medicine in 1957, and joined the staff of the University of Missouri-Columbia Medical School in 1961. Over the past 13 years he has made varied and valued contributions to both pathology, and medical school administration. From 1966 to 1967, while on a sabbatical, he was associate director of the Division of Regional Medical Programs at the National Institutes of Health; he then returned to Missouri-Columbia as both professor of pathology, and dean of the medical school. He served as the chairman of the National Board of Medical Examiners' Goals and Priorities (GAP) Committee, which produced the now famous GAP Report entitled, "Evaluation in the Continuum of Medical Education."

A copy of the GAP Report was provided to all of you who attended last year's SAC meeting. Because of the potential impact of this report on graduate medical education, we now invite Dr. Mayer to discuss this report with us, first-hand.

"Evaluation in the Continuum of Medical Education: The GAP Report of the National Board of Medical Examiners" —

William Mayer, M.D.:*

Just two corrections to Steve's kind introduction. One is that there is no such thing as an ex-Marine;

*Dean, University of Missouri-Columbia School of Medicine.

there are only civilian Marines. And I would guess that probably there are no such things as ex-deans, only civilian deans.

At the annual invitational conference of the National Board of Medical Examiners (NBME) held in Mar 1974, the discussion was mainly focused on the report of the NBME Committee on Goals and Priorities entitled, "Evaluation in the Continuum of Medical Education." It happened to be my good fortune to chair what is now called the GAP Committee. I was an active participant in those discussions, and when Steve asked me at that time if I would be willing to participate in this meeting with you, I indicated I would be delighted to do so. That was before I received the letter of 14 Aug which suggested that in my 25-minute presentation I cover: (1) the background and purpose of the GAP Report, (2) criticism of the Report to date, (3) procedural progress regarding implementation to date, (4) relationship to Senate Bill 3585, (5) relationship to state and national certifying bodies, (6) relationships to national specialty certifying bodies, and (7) proposed relationship to Navy graduate medical education processes and procedures. Obviously, there's no way



WILLIAM MAYER, M.D.—A former Marine (1946-1948) and dean of Columbia-Missouri School of Medicine: "The difficulty with communication has become increasingly apparent, and frequently the intended message is quite different from the one which is eventually heard."

that that bolus can be ingested, let alone digested or regurgitated in the allotted time. What I will try to do, however, is to touch briefly on most of the issues and trust that we will have an opportunity to get at some of the questions you may have, in the discussion period to follow.

Before beginning the more formal part of my presentation, I would like to try to answer those often asked questions: what or who is the GAP Committee, and what is the Report? The Committee was established to provide the NBME itself with outside advice, counsel, and recommendations for long-range planning purposes. Once appointed, however, Committee members immediately realized that, as an evaluation agency, the NBME interrelated with almost the entire spectrum of medical education: medical students, medical schools, state medical boards, specialty boards, specialty societies, foreign medical graduates, and the accreditation system. It also was clear that a major review of the total scope of medical education relating to evaluation, certification, licensure, and accreditation would be necessary for the Committee to carry out its charge appropriately.

When NBME Executive Committee members were informed about this problem, they issued the following disclaimer:

It is recognized that the Committee on Goals and Priorities, in the pursuit of its charge, will of necessity view many aspects of the scope and future of medical education, and possible relation to the NBME. It is hereby recognized that it, the Committee, will have the right of publication of information and opinion it derives, without such publication, however, being evidence of acceptance of such findings, per se, as accepted policy of the NBME.

Thus, the report is not of the National Board of Medical Examiners, but is in fact a report to the Board from the Committee, which had complete freedom throughout its 2-year existence.

I'd like to briefly review for you the major recommendations of the Committee, to clarify what the recommendations really were. I have been amazed in the last 15 months to discover a number of criticisms based on interpretations that were exactly 180 degrees different from the actual Committee recommendations. The difficulty with communication has become increasingly apparent, and frequently the intended message is quite different from the one which is eventually heard. It is sometimes frightening!

In an attempt to enhance the communications process, then, let me take a moment to review the Committee's recommendations. It would appear to me that

there are 4 basic recommendations. The 1st recommendation is that a comprehensive qualifying evaluation be required at the interface of undergraduate and graduate medical education, to assure that individuals are competent to practice in the supervised setting of the graduate phase of medical education. This proposed evaluation would include both an external examination which the Committee called "Qualifying A," and an internal evaluation (called "Internal A") accomplished by the medical school to determine the individual's competency to treat patients under supervision.

The Committee further recommended that:

- The NBME, in association with the Federation of State Medical Boards, develop the external examination.

- Medical schools and their accrediting bodies undertake a major effort to provide ongoing intramural assessment of the knowledge, skills, and behavioral characteristics of their students.

- Such a comprehensive "evaluation A," both external and internal, provide the legal basis for the state licensure board to issue a permit to practice in a supervised setting.

- All U.S. and foreign medical school graduates be permitted to enter graduate training only after they have successfully met evaluation standards at the "A" level.

The 2nd major recommendation was that a comprehensive evaluation occur at the interface between the graduate phase of education and the practice or continuing phase. The Committee felt that this evaluation should include 2 examinations: an external examination called "Qualifying B," which should remain primarily the responsibility of the specialty board; and an internal assessment called "Internal B," accomplished by the institution responsible for graduate medical education to determine the individual's competency to assume independent responsibility for patient care. It was further felt that:

- Individual specialty boards, in cooperation with each other, should continue to improve qualifying specialty examinations.

- Graduate medical institutions and their accrediting agencies should undertake major efforts to improve the ongoing intramural assessment of performance of their trainees.

It was hoped that a full and unrestricted license to practice medicine would then be granted, based on: specialty board certification, graduate medical institution verification of competence, and such additional requirements as may be determined by the individual state medical boards.

The Committee recommended that, at the option of the individual states, a limited number of individuals

not seeking or achieving specialty board certification might also be granted a full and unrestricted license on the basis of: satisfactory completion of the original "Qualifying A" examination, graduate medical institution verification of competence for full and unrestricted practice, completion of a minimum of 2 years of graduate training, and such other additional requirements as may be determined by the individual state boards. I might comment here that 3 of the members of the Committee — Drs. Edith J. Levit, Melvin Sabshin and C. Barber Mueller — conducted a substudy of the U.S. medical graduates of the class of 1960, in order to determine what is occurring in the continuum of medical education in this country.

Published in the 7 Mar 1974 issue of *The New England Journal of Medicine*, the study demonstrated that 99% of the graduates completed at least 2 years of additional training beyond the M.D. degree; 86% completed residency training, and entered into the certification process; and 73% were board certified by Sep 1973. Individuals limiting their practice to family or general practice were excluded from these figures, since no boards were available to them at that time. It was assumed that, with the establishment of the American Board of Family Practice, individuals entering that specialty would follow a similar pattern. From these data then, I think it would be safe to assume that at an absolute minimum, 75% of U.S. medical graduates might follow the course of full certification, while 25% of U.S. graduates might follow the alternate route towards licensure.

The 3rd major recommendation was that a national research and development effort be undertaken to identify characteristics of physician performance, and to establish methods of measuring these characteristics.

The 4th recommendation was that institutions and organizations involved in education, evaluation, certification and licensure of physicians, and in the accreditation of educational institutions and programs, acknowledge their interdependent responsibility to each other and to society for assuring the professional competence of those individuals authorized to provide care. The Committee was impressed with the number of groups and organizations who have some piece of the turf in these arenas. The vigor with which each piece of turf is guarded is something to behold.

There are some movements toward sharing of ideas and to some degree, responsibility, which we viewed as encouraging. Time does not permit a lengthy discourse on all developments in this area, but I would like to discuss briefly with you some developments in obtaining a more coordinated structure in the accreditation process.

As most of you are aware, medical schools have been accredited for the past several decades by the Liaison Committee on Medical Education, which answered to the American Medical Association (AMA) Council for Medical Education, and the Executive Council of the American Medical Colleges. The newly established Liaison Committee on Graduate Medical Education is beginning to assume some overview responsibility for the 22 independent review organizations now concerned with graduate-level medical education and accreditation. Also, currently on the drawing board and very close to being formed is a liaison committee on continuing medical education; the possibility of establishing a Liaison Committee on Education of Allied Health Professionals is under discussion.

Within this structure, the Coordinating Council on Medical Education has been established to coordinate accreditation activities in all these areas. As most of you are aware, that Coordinating Council on Medical Education answers to the 5 parent bodies: the Association of American Medical Colleges, the American Board of Medical Specialists, the American Hospital Association, the AMA, and the Council on Medical Specialty Societies. Although the Council was set up to coordinate accreditation of programs, it also serves as a focal point for discussion of a host of issues that relate to medical education.

I'd like to briefly review some of the reactions to the GAP Report. The feature article in the 12 Apr 1974 issue of *Medical World News* called the report "explosive," saying: "The NBME's panel on goals and priorities made recommendations that could jolt the U.S. medical establishment to its foundation." I'm not sure that it has gone that far, but I do think that some of the goals espoused in the concluding paragraphs of the report itself have been reached. We hoped that this report would provide the stimulus for open discussion, sharing of ideas, and ultimately the sharing of responsibilities in the evaluation of professional competence; and those goals have, at least been partially achieved.

After having read a semifinal draft of this report, one of the wags on the Executive Committee of the NBME said, "One thing is for sure, you are bound to get some initial negative reaction to the report." This has indeed happened. Many basic science faculty members in the schools of medicine have decried removal of Part 1 of the National Boards from the licensure process, feeling that it may represent a major deterioration in the emphasis placed on basic science by medical schools. In spite of repeated attempts to convince them that Part 1 of the National Boards would still be available for utilization by the schools in any manner

deemed appropriate within their own curriculum, and that the basic science component in the "Qualifying A" examination should give added emphasis to the importance of basic science even in the critical years of medical school, many have not been dissuaded from their original point of view.

Various members of the individual state licensure boards and of the Federation of State Medical Boards have felt that the recommendations of the report imply the death of the FLEX examination, which over the last 5 years, through their efforts, has been accepted throughout the U.S. Many other state board members have felt that granting a license on the basis of specialty board certification is an abrogation of the state board's legal and legislative responsibilities for examination, and therefore they are opposed to that particular concept. On the other hand, many of the specialty boards have felt that linking specialty board examinations in any way to the licensure process would potentially lead to the watering down of the standards set by the individual specialty boards.

House officers have viewed the proposal of refusing to grant a full and unrestricted license to practice medicine until board certification as a demeaning of the resident role in the health-care system, and have spoken out vigorously on this subject through their 2 national organizations. Sometimes it is clearly implied that the lack of a full and unrestrictive license to practice during residency training will adversely affect the moonlighting that is going on throughout the country in emergency rooms. I won't comment further on that.

Then, every once in a long while, I hear a voice from the wilderness claiming that the report is the most significant contribution to medical education since Flexner.

I would like now to review some of the actions taken by various groups, both during and after the publication of the report itself. For the sake of simplicity, the report divided the continuum of medical education into 3 areas: undergraduate, graduate, and continuing education. The evaluation procedures instituted in each of these phases were called, respectively, "A," "B," and "C." It was envisioned that at least 2 types of evaluation would occur: external evaluation carried out by agencies external to those responsible for the educational process, and internal evaluation procedures carried out by the institution or organization responsible for the educational process. The various procedures were therefore called *external A, B and C*, and *internal A, B and C*. Under this kind of construct, the licensure system carried out by the individual state board, which is in a sense a 3rd evaluation, would need to be integrated with the external and internal evaluations more effectively than is presently the case. For the

sake of completeness, original licensure is envisioned occurring sometime during the graduate education phase, with relicensure occurring during the continuing education phase.

Concerning external evaluation level A, there is an increasing likelihood that a single external qualifying examination will ultimately be developed which must be passed by all individuals entering into graduate medical education. The NBME has appointed an advisory committee on undergraduate medical evaluation, chaired by Dr. E. Pellegrino, who has recommended that "with the advice and assistance of other appropriate agencies, [the National Board] should proceed with the design of a proposed comprehensive qualifying examination." Although the form and actual content of such an examination, to be administered at or near the completion of undergraduate medical education, has yet to be developed, it is clear that the NBME is committed at least to developing a prototype of such an examination.

Second, the concerns about adequacy or inadequacy of foreign medical school graduates that are being expressed in multiple quarters are also exerting significant influence in the direction of a single qualifying examination for everyone entering graduate medical education. The following excerpt from a position paper adopted by the Executive Council of the Association of American Medical Colleges in Jun 1974 is but one example:

Admissions Criteria. The process of certifying foreign medical graduates for admission to graduate medical educational programs in the U.S. is inequitable and inadequate. In order to apply the same standards to all medical graduates it is recommended that a generally acceptable qualifying examination be developed as rapidly as possible, and be made a universal requirement for admitting all physicians through approved programs in graduate medical education. Until such an examination becomes available, Part 1 and Part 2 of the National Board exams, or the FLEX exams should be required.

Let me move on to what has happened in the "external B" arena. The specialty boards are individually and collectively attempting to improve the quality of their certifying exams. The NBME currently assists 12 specialty boards, and an equal number of subspecialty committees in developing written certifying examinations. In addition, specialty boards are now carrying out discussions with the NBME concerning potential mutual involvement. The Committee on the Study of Evaluation Procedure (COSEP) of the American Board

of Medical Specialties (ABMS) is developing methods and mechanisms for sharing information about methodologies for initial certification that have been developed by the 22 individual member boards. The COSEP is also planning meetings with the NBME to study potential mechanisms of shared, computerized pools of test questions.

Now to comment on the "external C" level. There is a rapidly increasing momentum for developing recertification procedures for individuals in various specialties. Although the precise requirements for recertification are not yet established (continuing education, re-examination, etc.), the commitment for the development of recertification procedures has been made. At the annual ABMS meeting in Mar 1973, the following action was endorsed:

That the ABMS adopts in principle, and urges concurrence of its member boards, the policy that voluntary, periodic recertification of medical specialists become an integral part of the national medical specialty certification program; and, further, that ABMS establish a reasonable deadline when voluntary periodic recertification of medical specialists will become a standard policy of all member boards.

Both the COSEP and the ABMS standing committee on certification, subcertification, and recertification are developing ways to share information about recertification procedures, which are now being developed by the individual member boards. Thus it is highly likely that, in the future, physicians will face the formal reevaluation of recertification and "external C" evaluation will also evolve.

Let me now turn to internal evaluation at the A level. No formal organized national effort to enhance evaluation procedures carried out by individual medical schools has emerged since the publication of the GAP Report. However, it is likely that increased emphasis will be placed on such evaluation in view of the increased ferment in the medical education role of devaluation, and the growing numbers of questions being raised in local, state and federal courts by medical students who challenge the adequacies of evaluation procedures that led to their dismissal. I can assure you, having been in the Kansas City Federal Court only about 8 weeks ago, that to stand before a Federal Court judge to justify dropping a student from the school rolls does increase motivation for developing adequate evaluation procedures. Progress in this area will occur at the individual medical school level, and will also probably be stimulated by the accreditation process at the national level.

At the internal B level, which is your ball park, more formal evaluation procedures than now exist will most likely be developed for future graduate medical education programs. A policy statement on the responsibilities of institutions and organizations offering graduate medical educational programs was adopted by the Coordinating Council on Medical Education (CCME) on 29 Mar 1974. It contained the following:

The teaching staff and administration, with review by the governing board, must: (a) establish the general objectives of graduate medical education; (b) apportion residency and fellowship positions among the several programs offered; (c) review institutional plans for each specific program; (d) develop criteria for selection of candidates; and (e) develop methods for evaluating, on a regular basis, the effectiveness of the program and the competency of persons who are in the program.

This statement is now being processed through the 5 parent organizations of the CCME, and although it may be modified in some detail, I feel the basic concepts have a good chance for approval. There will be increasing emphasis placed on the evaluation procedure (that is, internal B) during the graduate medical education phase of the physician's training.

It is unclear what the precise mechanisms of internal evaluation will be at the C level, occurring during the continuing or practice phase, but some review will take place. While some degree of review has always been carried out by hospital staffs, the magnitude of this review was enhanced by the requirements of the Medicare and Medicaid legislation.

A significant further enhancement of this process has now been stimulated by the passage of Professional Standards Review Organization (PSRO) legislation. PSRO organizations are now being formed throughout the U.S., and are developing the criteria by which individual hospital review programs will be approved. Not only is it unlikely that this trend will be reversed, it is actually more likely that the program will be broadened to include coverage of private clinics and private offices; there will probably be a similar broadening in the extent and depth of the review required. Hence, it is quite likely that ongoing internal C type evaluations will be encountered throughout a physician's entire practice.

I'd like to comment briefly on 2 general issues influencing this development. I indicated earlier that it is as yet unclear how licensure and relicensure will fit into this proposed scheme of evaluation. There is little doubt that the individual state medical boards will

retain their legislative and legal authority for licensure. It is also highly likely that the vast majority of those boards, currently all but 3, will accept the successful completion of Parts 1, 2, and 3 of the National Board examinations as an internal examination for licensure, as long as the NBME continues to produce those examinations. Furthermore, it is highly likely that the boards will continue to utilize the FLEX examination, currently approved by 48 states, as another alternative to qualify for licensure.

Whether the Federation of State Medical Boards (FSMB) or the individual state boards will accept the proposal of Dr. John Morton (vice-president of the FSMB), as published in the May 1974 issue of the *Federation Bulletin*, remains to be seen. Dr. Morton suggested that the boards give consideration to requiring Qualifying A examination, 2 years of graduate medical education in an approved training program, and successful completion of the FLEX examination as minimum requirements for initial licensure. It remains to be seen whether individual state boards of the Federation would, as the other alternative, espouse the proposal of the GAP Committee which, in effect, would provide licensure with the passage of Qualifying A examination, completion of graduate education, and certification by 1 of the 22 specialty boards.

There is also increasing pressure towards relicensure. As with recertification, the format of the procedure to be utilized is somewhat unclear: shall it take the form of required continuing education, required recertification, reexamination, or what? Although the state medical boards are somewhat behind the specialty boards in this regard, significant momentum was provided by a report from the Commission on Medical Malpractice, Department of Health, Education and Welfare. The report offered sweeping recommendations for continuing education, relicensure, recertification, and the structure of state licensure boards. Again, it is highly likely that some additional reevaluation procedure will be required for licensure throughout a physician's lifetime of practice.

I'll skip the details about ongoing research and development activities. But let me say that some major thrusts have been developed in the whole evaluation process relating to physician performance, particularly in problem-solving and the noncognitive areas of the learning process.

You are obviously far better prepared than I to relate the implications of these issues to the continuum of medical education in the U.S. Navy. It would seem to me, however, as an outsider looking in, that you are not only in a position to respond to some of these trends, you may well be in an almost unique position

to provide leadership in developing meaningful models of the educational continuum.

I cannot think of another system at the graduate medical educational level which could more readily demonstrate the applicability of evaluation models in multiple programs. For example, an individual school of medicine could: (1) define the knowledge, skills, attitudes, and behaviors common to all 22 primary specialty boards; (2) express these factors as educational objectives in behavioral terms; and (3) develop valid and reliable evaluation instruments for use by every specialty. That same medical school could also go through similar processes specific to each of the individual specialty areas, assuming that there had been input from related specialties concerning those developments. But even if a given medical school were able to get this job done, and I might add that to my knowledge none have done it yet, the evaluation would suffer from 3 possible deficiencies. First, the number of faculty members in given specialties may be sufficiently small to bias the soundness of the educational objectives developed; second, it is doubtful whether there is a single medical school in this country with sufficient educational-resource backup for such a total effort; and third, other schools may be reluctant to accept the evaluation programs developed within a single school.

On the other hand, within the Navy graduate medical educational program there are 35 specialty and subspecialty areas. Clearly there must be appropriate representation of each specialty, either sufficient internal educational support services or the capacity to contract for them, and obvious mechanisms to share the evaluation program once it has been developed.

A 2nd rather unique feature which you possess is the ability to build bridges between the graduate and continuing practice stages of the educational continuum. The independent hospitals, academic health centers, and even the Veterans Administration system lose the vast majority of their students to totally different spheres of influence once graduate medical education has been completed. Your losses are not nearly so great. Thus you have unique opportunities to develop experimental evaluation and educational programs, which would involve the physician from his entrance into residency through the duration of his practice. Indeed, with the coming of the Uniformed Services University of the Health Sciences you may have the only model of a true educational continuum, from entrance into medical school to the cessation of practice.

While I realize that such complex efforts in evaluation throughout the continuum of medical education may appear, on the surface, to stifle innovation in the

educational system, I feel the opposite is the case. The tendency has been to make the newer programs conform to the educational processes and procedures of the older programs; however, this has been done not out of malice or desire for conformity, but as an expression of a valid concern that the students of the newer program be qualified when they complete their particular phase of education. If we had valid and reliable evaluation procedures and devices to measure the students' qualifications, our concerns for the educational process would lessen and experimentation in medical education would flourish.

Clearly, one of the greatest inhibitors of getting this task accomplished is implied in Robert Ardrey's book about territorial imperatives. Questions are raised as to national versus institutional prerogatives (that is, BUMED versus Bethesda), and institutional versus departmental prerogatives in establishing an evaluation procedure; sometimes even departmental versus individual faculty prerogatives are discussed under the rallying banners of academic and personal freedom.

In case you don't understand how individual rights, privileges, and prerogatives work in the educational evaluation system, an evaluation instrument will be administered following the group discussion, to measure the knowledge you have gained from this educational experience. Obviously, I did not state my educational objectives and behavioral terms at the outset of my talk; equally obviously, I alone developed the educational program and evaluational instrument. And, finally, if you fail to achieve a minimum pass level, that's your fault and not mine, for I knew all along what I expected you to learn from this experience. Thank you.

"The Uniformed Services University of the Health Sciences" —

*CAPT Melvin Museles, MC, USN: **

I'd like to bring you up to date on some of the milestones we have passed during the last year, while establishing the Uniformed Services University of the Health Sciences (USUHS). Dr. Curreri will then discuss the university in a little more detail, and will describe some of its goals and objectives.

Appointed by the President of the United States between May and Jul 1973, the Board of Regents of the USUHS has made tremendous progress. We have established a site for the University at the National Naval Medical Center in Bethesda, Md. We have developed

the University into a separate agency of the Department of Defense. The Board of Regents reports directly to the Secretary of Defense, and Dr. Curreri, president of the USUHS, reports directly to the Board of Regents; so the chain of command goes directly to the Office of the Secretary of Defense.

The members of the Board of Regents are a very distinguished group of individuals responsible for the policy of the University. The current Board members are listed in Table 1.

TABLE 1.—USUHS BOARD OF REGENTS

Mr. David Packard Chairman of the Board Hewlett-Packard Co. Palo Alto, Calif. Former Deputy Secretary of Defense
LTGEN Leonard D. Heaton, USA (Ret.) Pinehurst, N.C. Retired Surgeon General, U.S. Army
Malcolm C. Todd, M.D. Long Beach, Calif. President, American Medical Association
Charles E. Odegaard, Ph.D. Seattle, Wash. Retired president, University of Washington
Joseph D. Matarazzo, Ph.D. Portland, Oreg. Professor and chairman Department of Medical Psychology University of Oregon Medical School
H. Ashton Thomas, M.D. New Orleans, La. Physician and surgeon
Philip O'Bryan Montgomery, Jr., M.D. Dallas, Tex. Professor of Pathology The University of Texas Southwestern Medical School
Durward G. Hall, M.D. Springfield, Mo. Retired member, U.S. House of Representatives
Alfred A. Marquez, M.D. San Francisco, Calif. Physician and surgeon

*Executive Secretary to the Board of Regents, USUHS.

TABLE 1.—USUHS BOARD OF REGENTS (Con.)

Ex-officio members are:

James R. Cowan, M.D.
Washington, D.C.
Assistant Secretary of Defense
(Health and Environment)

LTGEN Richard R. Taylor, MC, USA
Washington, D.C.
The Surgeon General
Department of the Army

VADM D.L. Custis, MC, USN
Washington, D.C.
The Surgeon General
Department of the Navy

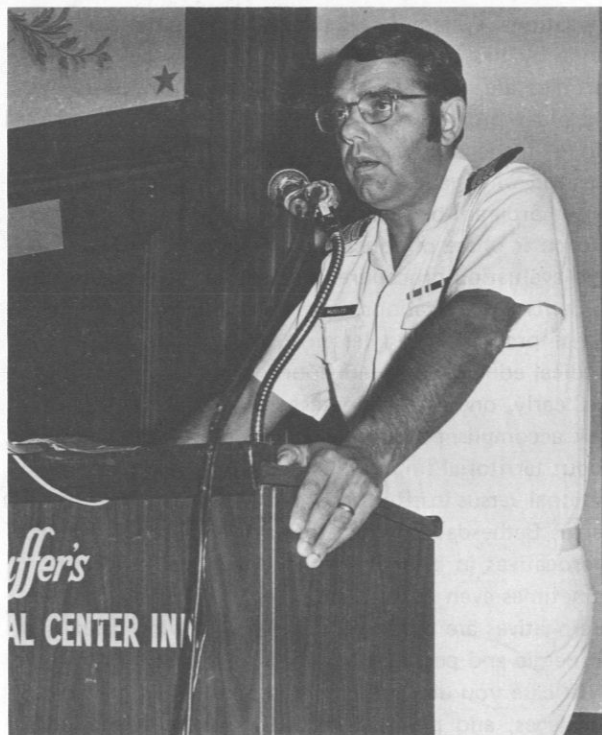
LTGEN Robert A. Patterson, MC, USAF
Washington, D.C.
The Surgeon General
Department of the Air Force

Dr. Lionel Bernstein
Rockville, Md.
Director of Program Operations
Department of Health, Education and Welfare
Health Resources Administration
(Representing Assistant Secretary,
Department of HEW).

The preliminary organizational chart for the USUHS is shown in Figure 5. As the institution develops and expands, deans of all the various schools will be appointed (See Figure 6), and fruitful collaboration with the various academic military institutions is envisioned, involving all the health sciences.

We are currently planning to start the first class of 36 students next fall at the Armed Forces Institute of Pathology (AFIP), and are redesigning approximately 30,000 square feet of space there for that purpose. At the same time, we are developing the first phase of the basic science building which will be constructed at the National Naval Medical Center. We hope to have that unit ready by the fall of 1976, to accommodate a fairly large class of medical students.

Now I'm going to introduce Dr. Anthony R. Curreri, appointed the first president of the USUHS in Jan 1974, who will discuss the university with you in greater detail. Dr. Curreri, we are proud to have you with us today.



CAPT M. MUSELES, MC, USN.—Executive secretary of the USUHS Board of Regents.

"The Uniformed Services University of the Health Sciences" —

*Anthony R. Curreri, M.D.:**

It's truly a privilege to be here with you. I particularly enjoyed being with you yesterday, because it was an education for me to learn of your plans and activities in the area of health education. As a matter of fact, here in Washington my humility knows no bounds as I observe the Federal Government and Department of Defense in operation.

Many things will be done in the course of establishing the USUHS that may later have to be corrected or modified because I may have failed to understand some of the operations which involve 1 of the 3 services, or even the Department of Defense. So I think it's important that we do have open communication and understanding, as Dr. Mayer stated; only then can we hope that this complex development will meet with success.

At the very outset I would like to say that the Navy Medical Corps could have no better champion than VADM Don Custis. He has foresight, and he has insight.

*President, USUHS.

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

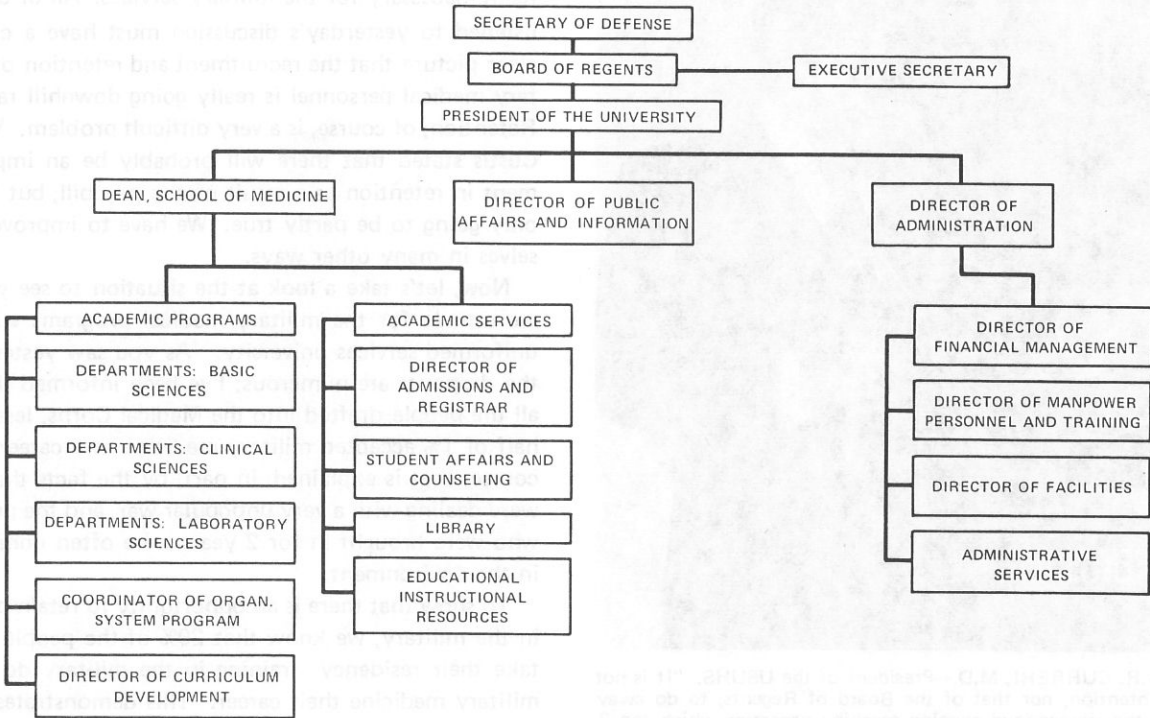


Figure 5

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

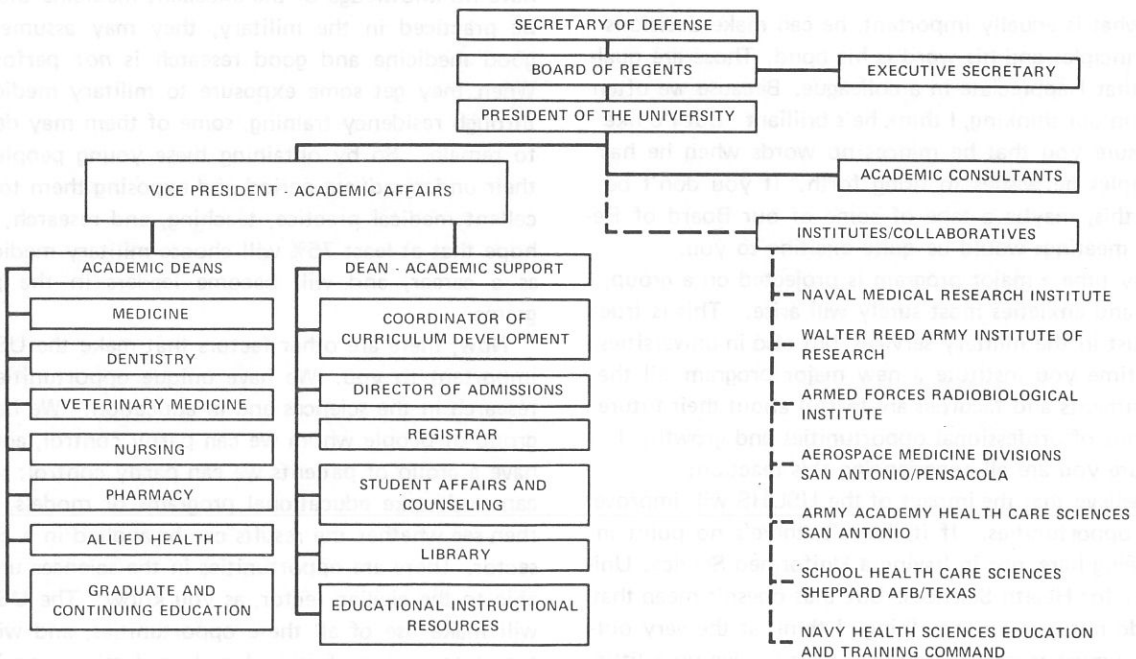


Figure 6



A.R. CURRERI, M.D.—President of the USUHS. "It is not my intention, nor that of the Board of Regents, to do away with the tremendous ongoing teaching programs which the 3 services have established . . ." We will build them and keep them where they are, instead of dissolving them and trying to transport them to Washington.

But what is equally important, he can make decisions on principles and his word is his bond. Those are qualities that I appreciate in a colleague. Because we often agree in our thinking, I think he's brilliant. But I'd like to assure you that he minces no words when he has principles he wishes to bring forth. If you don't believe this, maybe a tape of some of our Board of Regents meetings would be quite exciting to you.

Any time a major program is projected on a group, fears and anxieties most surely will arise. This is true not just in the military services, but also in universities. Any time you institute a new major program, all the departments and faculties are fearful about their future in terms of professional opportunities and growth. I am sure you are all experiencing this reaction.

I believe that the impact of the USUHS will improve your opportunities. If it doesn't, there's no point in my being here, nor in having a Uniformed Services University for Health Sciences. But that doesn't mean that you do not give up something. I think at the very outset you must recognize you may have to give up a little to gain a lot. I'd like to have you keep this in mind.

Now some of you may be questioning whether a Uniformed Services University for Health Sciences is really necessary for the military services. All of us who listened to yesterday's discussion must have a crystal clear picture that the recruitment and retention of military medical personnel is really going downhill rapidly. Retention, of course, is a very difficult problem. VADM Custis stated that there will probably be an improvement in retention as a result of the pay bill, but this is only going to be partly true. We have to improve ourselves in many other ways.

Now, let's take a look at the situation to see what we can do for the military medical programs with a uniformed services university. As you saw yesterday, the dropouts are numerous; I've been informed that of all the people drafted into the Medical Corps, less than half of 1% accepted military medicine as a career. Of course, that is explained, in part, by the facts that we were dealing with a very unpopular war, and the people who were brought in for 2 years were often unhappy in the environment.

To show that there is an opportunity to retain people in the military, we know that 20% of the people who take their residency training in the military do make military medicine their career. This demonstrates that good exposure to military medicine will serve to retain some people for a military career.

But it's more than that. Students, particularly undergraduate students, emulate and follow in the footsteps of their teachers. Since many young medical students have no knowledge of the excellent medicine that can be practiced in the military, they may assume that good medicine and good research is *not* performed. When they get some exposure to military medicine through residency training, some of them may decide to remain. So by obtaining these young people in their undergraduate period and exposing them to excellent medical practice, teaching, and research, we hope that at least 75% will choose military medicine as a career, and will become leaders in the programs.

Now, there are other factors that make the USUHS important to you. We have unique opportunities for research in the sciences and in education. We have a group of people whom we can partly control, and we have a group of patients we can partly control; so we can undertake educational programs or models, and then see whether the results can be applied in a civilian sector. There are opportunities in the sciences unavailable to the civilian sector, as you know. The USUHS will make use of all these opportunities, and will attempt to gain professional and academic recognition for all who participate in the programs.

The military are also losing many people who would like to climb the academic ladder, who feel that such an opportunity has not been present. This opportunity will become available through the USUHS. There will also be the opportunity for qualified young people to be considered for appointments in the USUHS, and to be assigned to the staff of the university hospital. Finally, the USUHS will authorize the granting of certificates or the issuing of degrees, both at the baccalaureate and at the graduate level.

Now this does not mean that the USUHS will totally answer all of our needs. We still have the problem of retaining people by making the military situation professionally and socially rewarding. By "socially rewarding," I'm referring to the wives. You all know that this is sometimes a difficult problem when a poor assignment is given. But yesterday I took heart when VADM Custis said that no one will be assigned to an administrative post, a command post, unless he so desires. I think this will be an important consideration for many people.

Another question frequently heard is, "When will the University become operational?" We are hopeful that we will be able to initiate our first class in Sep 1975. Now we have many difficulties before us, but on the other hand, we do have some special opportunities not available to the average, newly developing, medical school. We have on hand a large number of military men who will qualify for academic appointments. We have people in the National Institutes of Health who could qualify. What we really must have, then, is a dean and a corps of department chairmen with whom we can establish such a school.

Now the question arises as to why I haven't obtained a dean by this time. Many friends ask, "Why are you holding out?" And my answer is that until we have obtained temporary facilities in which to start the class, until we can develop and initiate our permanent facility, until I have funding for the program, and until agreements have been reached concerning the operation of the university hospitals, I am unwilling to bring a dean on board.

We now have the temporary facilities. We have funds with which to start our first increment of classes. General agreements have been reached with the 3 surgeons general in the operation of 3 university hospitals. As a result, we now have a search committee which has reviewed the applicants for the deanship, and, hopefully, within 3 months a dean will be appointed. By law, the dean must be a civilian.

Department chairmen may be civilian or military. Selection of department chairmen will be completely based on the ability of the individual to do the job. I

emphasize that the man must be able to manage the job; so many men have been ruined because they lacked the necessary qualities to lead or direct men, programs, and a department, although they may have done an excellent job in research or in teaching. I've seen more assistant deans who were appointed because of the "Peter Principle" than we have deans. Whenever you see more than 10 assistant and associate deans, you know that there has been trouble with chairmen. So we want to see to it that anyone named chairman is not only professionally qualified for the job, but is also a leader. Equally important, he must have empathy, and an understanding of military operations.

The professorial appointments will be very much like professorial appointments in any university. A person at the professorial level must be responsible for a program, as a leader of programs. The same is true of an associate professor. He must be able to stand on his own 2 feet and run his own program, or at least be responsible for an operation.

What do I mean by a program? It would be either educational, combined with service or research, or it could be research combined with education. But it seems to me that unless a man is very unusual, just having one field is not enough. If a man is an outstanding surgeon but doesn't wish to teach, he can be happy in a large institution which has a nonteaching program. On the other hand, if he is really a good educator and he does good service work, I'm not so interested in how much research he turns out.

I am hopeful that each department will assess itself and its personnel, at regular intervals of time. One of the failings of universities has been that they do not do this, and very often departments go downhill. If some people do not maintain their momentum, you ought to bring in new blood to maintain high quality programs in the university.

The assistant professorial level is somewhat different, being comprised of junior people in the program. They're being tested and they will, of course, be able to achieve this level without having demonstrated the ability to run a total program.

What will be our relationship with the teaching hospitals? Well, at the very beginning we will interrelate with the 3 USUHS-affiliated hospitals: the National Naval Medical Center, Walter Reed Army Medical Center, and Malcolm Grow USAF Medical Center; the latter will be used for family practice. There is some discussion about whether we will use Wilford Hall USAF Medical Center, but its location in San Antonio, Tex., precludes its practical use for more than clerkships.

We hope that in time the USUHS will become the umbrella for all teaching hospitals, and that the people

in these teaching hospitals can be appointed to the University faculty. On the other hand, a hospital might prefer to remain affiliated with a local university. At the present time I have no argument with the latter option. But the hospitals cannot have a double affiliation, so they must decide where their greatest growth could be realized.

We would like to have the USUHS eventually function as an umbrella for all teaching hospitals, for a number of reasons. First, individuals qualifying for certification for graduate or technical training can receive their certification from the USUHS through the hospital where they are employed. Accreditation can be achieved in this manner.

There is a second consideration: if an individual is appointed to an academic rank at the University Hospitals and after a period of time is reassigned elsewhere to another position of equal responsibility, we could continue his appointment as a member of the USUHS and he would not lose his academic rank. Moreover, we will ask all members who have actual rank as professors, associate professors, or assistant professors to help with departmental development, whereas individuals without a USUHS appointment will not be able to participate.

Many of you may also be wondering about the impact of USUHS on ongoing teaching programs, such as allied health and other training programs. At the present time my major and practically only interest is in the medical school. But I also recognize the tremendous ongoing teaching programs which the 3 services have established in many areas, and it is not my intention, nor that of the Board of Regents, to destroy these excellent programs. We will build them and keep them where they are, instead of dissolving them and trying to transport them to Washington. We cannot disrupt excellent programs which are functioning very well, and we will continue them. In fact, we hope that accreditation and the certification or degree-granting authority for these programs will eventually come from the USUHS.

The question of tenure has also been discussed with the 3 military surgeons general, and the Board of Regents. Civilians will be given tenure somewhat similar to that given in universities; that is, instructors will receive a 1-year appointment, on an annual basis. Assistant professors will be appointed on a 3-year basis, unless a 1-year appointment is approved in advance.

Associate professors coming from outside the military will be given a 3-year appointment. The reason for this

limitation is that my experience with universities has demonstrated very clearly that many people gain a reputation and write many articles when they are associated with an outstanding man. On the basis of his publications and reputation, we may bring an individual into a university as an associate professor, only to find that he is a highly developed technician; but by then we are stuck with a man with tenure. We have therefore decided that anyone from the outside who enters the USUHS as an associate professor, and who has not been evaluated, must be assessed over a 3-year period before permanent tenure can be given.

Full professors are given tenure. Immediate tenure is necessary, because I think it would be hard to fight this point with the Association of University Professors.

What about support to departments? Well, I am very hopeful that the complete educational aspects will be supported by the University. I think it's unfair to ask the military services to provide complete support for these educational aspects. We have done so in civilian universities, of course, where research or operational funds are used to support education, or operational funds are used to support research. Congress must learn that it costs money to educate people. As a matter of fact the funds which we requested this year were granted, and we got the last dollar that we requested for educational purposes.

Now, why are we establishing the medical school first? Well, Congress recognizes the need for physicians, and places the highest priority on medical education, with the initiation of the other schools to follow later. I would like to remind you that the laboratories will be built in the 2nd phase of our building program, with consideration for *all* the schools that eventually will be included in the University.

It is my firm hope that this will be a high quality University. It cannot succeed through its administration alone. It can only succeed by the spirited participation of all who are involved in the teaching program, and in the research program as well. Therefore, it is up to you to help us make this a worthy institution. It means we may have to work harder, it means we may have to give up a few things; but in the long run, if we utilize the resources that are available in the 3 services and in the allied institutes, and if we work together properly and cooperatively, we should have one of the outstanding universities for health sciences in the world.

Thank you very much. 🍀

Extracorporeal Repair of Renal Artery Aneurysm

By LCDR Richard Milsten, MC, USNR
Assistant Chief of Urology
Naval Regional Medical Center
Philadelphia, Pennsylvania 19145

SUMMARY

A recent innovation in the urologic armamentarium is extracorporeal renal surgery which has been popularly termed "workbench" surgery. This refers to ex-vivo repair of the kidney, followed by autotransplantation.

The urologic indications for renal bench surgery are still being defined. To date, most cases have been performed for renovascular disease: stenosis, fibromuscular hyperplasia, and aneurysm. Other cases which have been similarly treated include trauma, renal cell carcinoma, and staghorn calculi.¹

The extracorporeal technique offers several advantages: a totally bloodless field; the easy application of the operating microscope, if necessary; a longer ischemic time for repair and accurate arteriographic studies, prior to reimplantation.

Renal preservation during repair may be accomplished either with simple hypothermia or pulsatile perfusion,

and the specifics of each technique are discussed elsewhere.¹

On 22 Jul 1974, extracorporeal surgery was carried out at the Naval Regional Medical Center, Philadelphia, to repair four renal artery aneurysms affecting a single kidney. (See Figure 1.) The aneurysms involved the primary, secondary and tertiary vessels. Renal preservation was accomplished by means of hypothermia, and the cold ischemic time was 4 hours. The involved left kidney was transplanted to the right iliac fossa after ex-vivo arteriography had demonstrated successful repair. The patient is doing well at home, and follow-up renal scan and renogram show excellent function.

CASE REPORT

A 44-year-old lady was admitted to the Naval Hospital Philadelphia, on 18 Jul 1974, for further investigation and surgical treatment of renal artery pathology. Five years previously she had required medical attention for hypertension, at which time a pyelogram study was said to have appeared normal. The hypertension was apparently controlled by combined therapy, and daily oral medications at the time of hospitalization included: hydrochlorothiazide, 100 mg; reserpine, 0.375 mg; hydralazine hydrochloride, 75 mg; potassium

The opinions or assertions contained herein are those of the author and are not to be construed as official, or necessarily reflecting the views of the Navy Department or the naval service at large.

The excellent medical photography, reproduced on the covers of this issue and within the above article, is credited to HM2 R.L. Creighton, USN.

1. Milsten R, Neifeld J and Koontz WW Jr: Extra-corporeal renal surgery. J Urol 112:425, 1974.

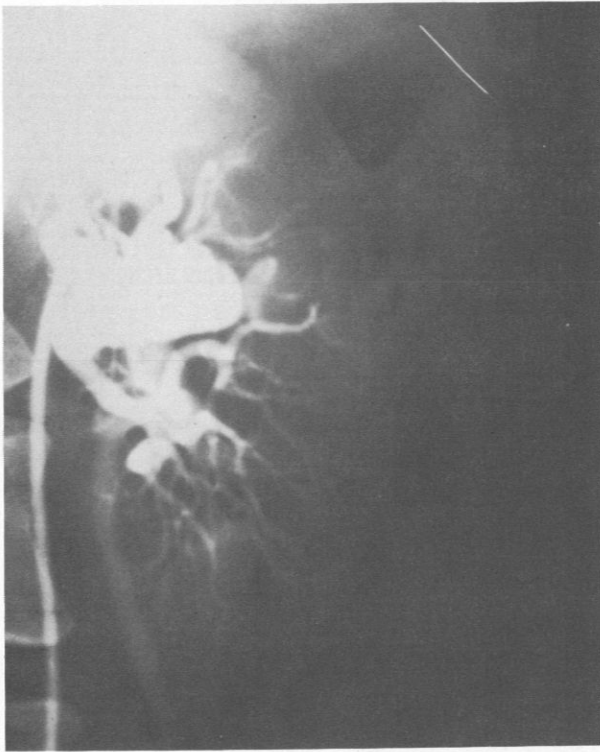


Figure 1.—Selective arteriogram shows large, expanding intrarenal aneurysm of the left renal artery.

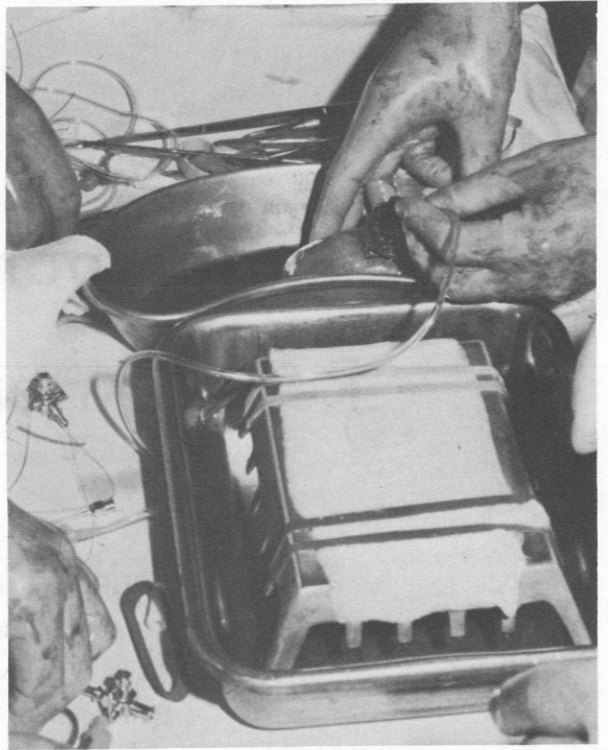


Figure 3.—The kidney is flushed until all blood is washed out. The bench is in the foreground.



Figure 2.—The bench is readied to receive the kidney.

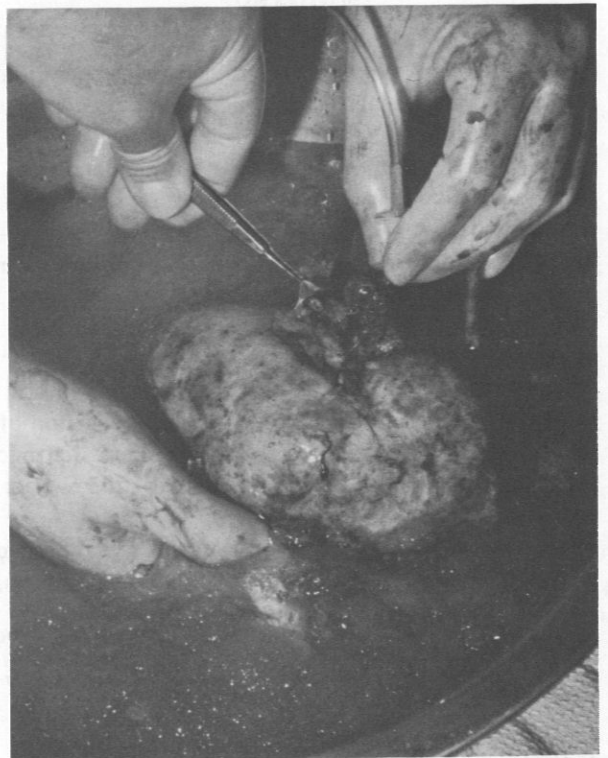


Figure 4.—The wash-out is completed as the kidney is immersed in sterile ice slush.

supplement; and diazepam. The patient denied flank pain, gross hematuria, cardiac disease, and claudication.

Several months before admission the patient presented lower urinary tract symptoms that led to an intravenous pyelogram study, which revealed a circular calcification in the region of the left renal artery. Subsequent angiographic study disclosed a broken calcification within the wall of an aneurysm located at the main left renal artery, just at or within the bifurcation of the main renal artery; moderate medial fibroplasia of the right renal artery was suggested. During the angiography, a peripheral run-off study revealed evidence consistent with a diagnosis of moderate atheromatous disease of the distal aorta, with no occlusion and apparently normal hypogastric arteries. Cystoscopic examination had been unremarkable except for mild urethral stenosis. On the basis of this evaluation, surgical plans were made to explore the left kidney, and attempt in-vivo repair of the left renal artery aneurysm; or remove the left kidney, if necessary, for ex-vivo repair of the aneurysm and subsequent autotransplantation of the left kidney.

A strong familial history of hypertension was noted. In addition to the usual childhood illnesses, the patient related a past medical history of febrile illnesses diagnosed as "pyelitis," without urologic evaluation. She was said to be allergic to some sulfonamide drugs and nitrofurantoin, and had never received a blood transfusion. She ceased to smoke cigarettes 5-6 years previously, after having smoked 1-1½ packs per day for 20 years. Past history and systems review were otherwise unremarkable, without evidence of tuberculosis, diabetes, myocardial infarction, cerebrovascular accidents, or other serious illness.

Physical examination disclosed 3+ carotid pulses bilaterally without bruits; femoral pulses were 3+ bilaterally with a mild right-sided bruit; distal pulses were 3+, without associated trophic changes or pedal edema; no abdominal bruits or flank tenderness were observed. The heart was not clinically enlarged; the sounds were of good quality; and a grade 2/6 soft systolic murmur was best heard at the base, without radiation. The remainder of a complete examination was not unusual.

Laboratory studies, including chest X-ray examination and electrocardiograms, revealed no additional abnormal findings.

OPERATIVE REPORT:

On 22 Jul 1974 the patient underwent ex-vivo repair of the left renal artery aneurysm with subsequent autotransplantation of the left kidney.

Following induction of anesthesia, the patient was placed in absolute supine position. A sterile field was

prepped and draped. Through a standard anterior sub-costal incision carried down to the skin and subcutaneous tissue, external and internal oblique and transversalis abdominis muscles, the peritoneal cavity was entered. The left colon was reflected, Gerota's fascia entered, and the kidney dissected free. The entire renal artery and renal vein were dissected to the aorta and vena cava, exposing a large 2-cm renal artery aneurysm outside the kidney hilus, in addition to several small aneurysms at the border of the hilus and within the parenchyma.

The ureter was transected below the level of the iliac artery, and the main stump was suture ligated with 2-0 chromic. The left renal artery and vein were doubly ligated against the aorta and vena cava, and the kidney was removed with 2 minutes of warm ischemic time. The anterior abdominal wound was closed.

Removed to a separate, sterile, prepared workbench (See Figure 2), the kidney was immediately perfused with 1000 cc of special solution of: lactated Ringer's mixture, 45 cc of 2% procaine, 15 mg of sodium bicarbonate, and 10,000 units of heparin. (See Figure 3.) The special solution had an adjusted pH of 7.65, and was cooled to 4°C. Having been immobilized on a specially designed bench, and after adequate efflux of clear effluent from the renal vein, the kidney was immersed in sterile ice slush (See Figure 4). Two aneurysms were bolstered with felt; after linear arteriotomy the wall of the 3rd aneurysm was excised, and the remaining vessel was sutured with 6-0 prolene; the 4th and most proximal aneurysm was entirely excised. Perfusion was maintained throughout the extracorporeal dissection, and the kidney was then immersed in solution. (See Figures 5-10.)

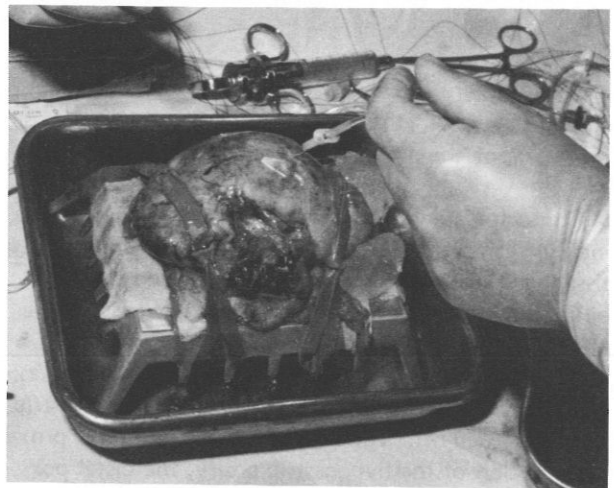


Figure 5.—The kidney on the bench prior to repair. (See photo in color on the front cover of this issue.)



Figure 6.—The patient's nephrectomy incision is closed as X-ray team gets into position.



Figure 7.—The kidney is injected for ex-vivo arteriography.

With the left kidney ex-situ, an arteriogram demonstrated patency of the entire arterial tree with successful repair of the 4 separate aneurysms. (See Figure 11.)

Through a standard right lower quadrant transplant incision carried down to the skin and subcutaneous tissue, the aponeurosis of the external and internal oblique muscles, and the transversalis abdominis, the extraperitoneal space was entered. The hypogastric artery was mobilized, the posterior gluteal branch was divided, and then the distal portion of the hypogastric artery was tied off. With a bulldog clamp on the proximal portion of the hypogastric artery, the distal portion was severed. All branches feeding the external iliac vein were tied off. (See Figure 12.)

supplement and dissection. The patient denied flank pain, gross hematuria, cardiac disease, and claudication. Several months before admission the patient presented lower urinary tract symptoms that led to an intravenous pyelogram study, which revealed a circular calcification

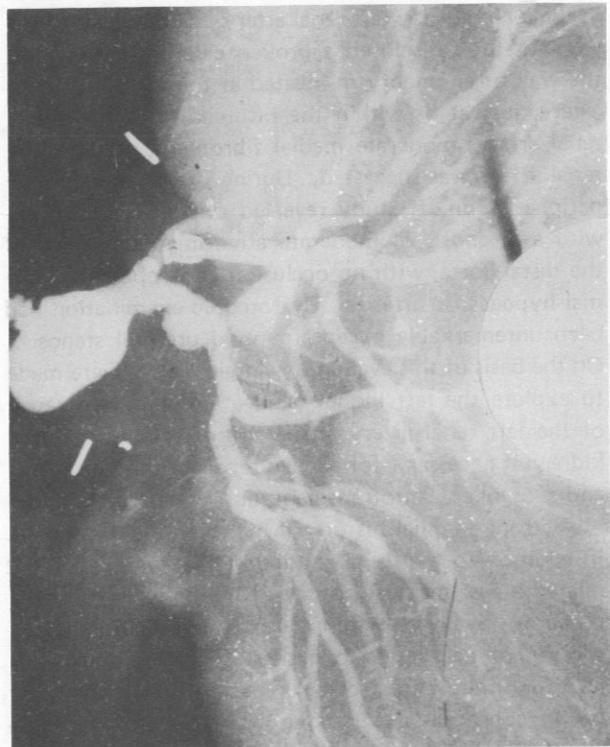


Figure 8.—Ex-vivo arteriogram performed at the bench shows diffuse disease and multiple aneurysms.



Figure 9.—Repair of four aneurysms begins at the bench.



Figure 10.—Repair of aneurysm is underway.

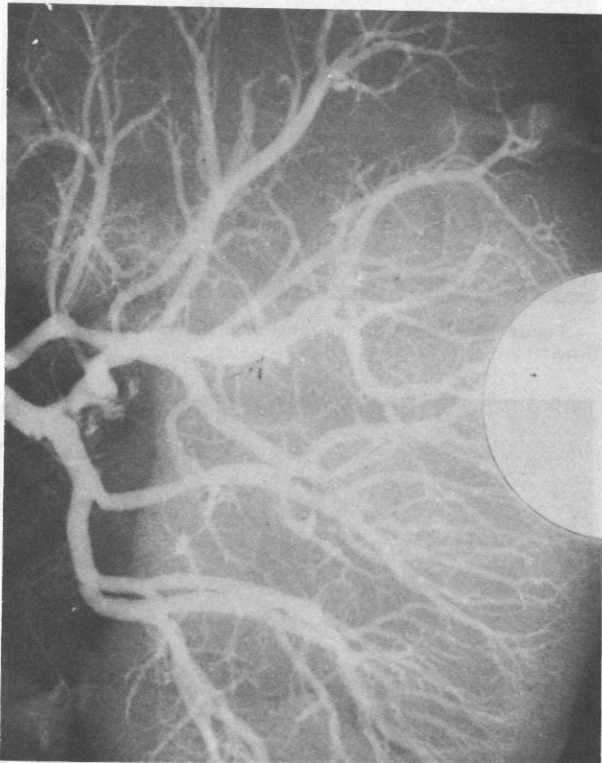


Figure 11.—Ex-vivo arteriogram shows successful repair.



Figure 12.—Transplant site has been prepared in the right iliac fossa and the left kidney is ready to be returned to the patient. (For color photo see back cover of this issue.)

The left kidney was returned to the operating table for anastomosis between the hypogastric and renal arteries using running 6-0 prolene. A linear venotomy was made in the external iliac vein, to which the renal vein was anastomosed in an end-to-side fashion with 6-0 prolene. End-to-end arteriole anastomosis between the hypogastric and renal arteries was created. The kidney immediately responded with excellent turgor. (See Figures 13-14.) Compression of the renal vein caused swelling of the kidney. Peristalsis and urinary efflux were noted. The bladder was entered and the ureter was drawn in through a small submucosal oblique tunnel, fishmouth. It was sutured in place with 4-0 chromic sutures. The bladder was then closed in a 2-layer fashion, using running 3-0 plain sutures on the mucosa and interrupted 2-0 chromic catgut sutures on the muscularis.

Some venous ooze from the kidney was noted, and was subsequently controlled. A capsulotomy was made along the lateral aspect of the kidney, from the upper to the lower pole. A hemovac drain was brought out retroperitoneally. The transversalis abdominis was closed with 0 chromic, and the internal and external oblique muscles were closed with interrupted 2-0 Tevdek sutures; the skin was approximated with 4-0 silk, and the subcutaneous with 4-0 plain.

The patient tolerated the entire procedure well, and was returned to the recovery room in satisfactory condition.

POSTOPERATIVE COURSE:

The immediate postoperative period was complicated by mild pulmonary atelectasis with a small right pleural



Figure 13.—The arterial anastomosis is complete. (For color photo see lower right picture on the back cover of this issue.)



Figure 14.—With blood flow reestablished, the kidney "pinks up" and begins to put out urine.

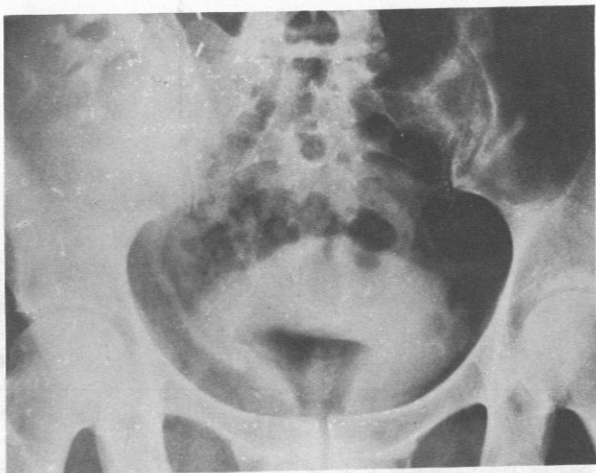


Figure 15.—Postoperative IVP shows the left kidney now located in the right iliac fossa.

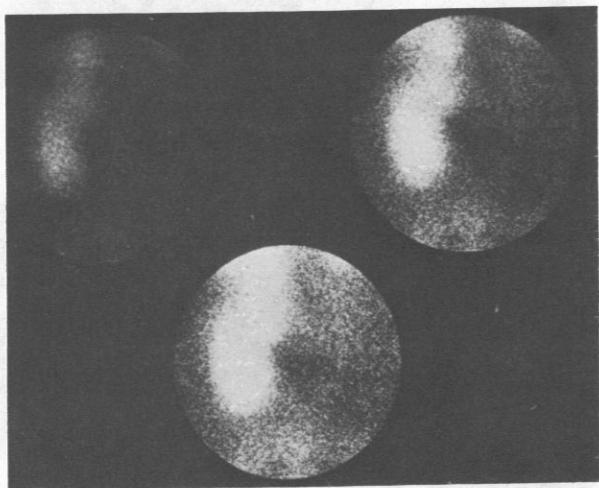


Figure 16.—Postoperative renal scan shows excellent blood flow.

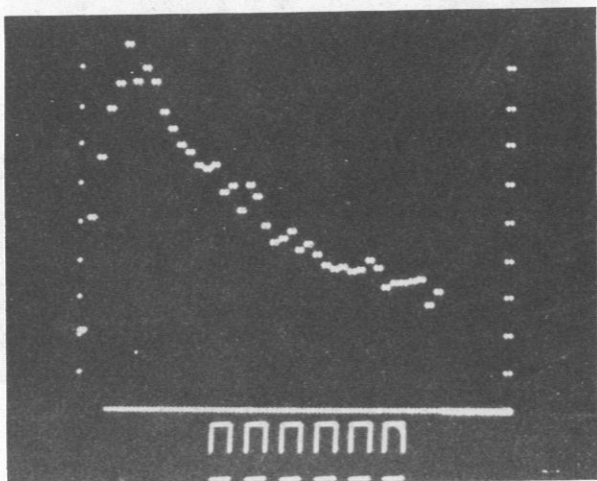


Figure 17.—Renogram shows a normal curve, 6-8 weeks postoperatively.

effusion, all of which cleared with progressive pulmonary toilette.

On the 2nd and 3rd postoperative days, renal scan studies demonstrated prompt function of the transplanted kidney which was of normal size. A mild obstructive pattern was observed by renogram study on the 3rd day.

The only disquieting feature in the postoperative course was persistent low-grade fever, in the absence of significant findings on repeated examination, chest X-ray studies, and urine cultures. On the 15th postoperative day, an intravenous pyelogram study revealed partial obstruction to the transplanted kidney, with grade-2 hydronephrosis and evidence of a moderate amount of fluid collected in the right pelvis. In the absence of gross renal infection, the obstruction was attributed to edema in the area of ureteroneocystostomy and conservative management was continued. In anticipation of spontaneous resolution of postoperative edema, the hydronephrosis was expected to diminish.

Throughout the early postoperative period the patient's blood pressure determinations remained in the range of 140/85 to 150/90, without antihypertension medication.

On 11 Aug 1974, the patient was discharged to home, to be subsequently followed in the Urology Clinic. At the time of her release, hematocrit and renal function tests were within normal limits; chest X-ray and electrocardiogram studies revealed no abnormalities.

FOLLOW-UP REPORT:

Within 6-8 weeks following surgery, the previously noted evidence of hydronephrosis had disappeared. Intravenous pyelogram, renal scan and renogram studies disclosed no abnormalities; and the patient remained clinically well. (See Figures 15-17.) Mild hypertension remains well controlled on minimal medication, using only one antihypertensive drug. ☸

CHINESE NAVY HONORS CAPT BURKHART



SIGN OF APPRECIATION.—CAPT Vernon A. Burkhart, MC, USN (right), CO of Naval Submarine Medical Center (NSMC), New London, Groton, Conn., accepts a plaque from CAPT Chen-hua Sha, chief of Professional Division, Bureau of Medicine and Surgery, Chinese Navy Headquarters. Offered on behalf of RADM Tzu-tu Chou, Surgeon General of the Chinese Navy, the plaque is a sign of appreciation for NSMC staff assistance in developing a submarine and diving medical training program in Taiwan. CAPT Sha also consulted with staff members on recompression chamber and training requirements. — PAO, NSMC, Naval Submarine Base, New London, Groton, Conn. ☸

RADM(D) A.E. CADMAN, RN VISITS NORFOLK



ROYAL GIFT.—RADM George A. Besbekos, DC, USN (left), CO of Naval Regional Dental Center, Norfolk, Va., presents a commemorative plaque to Surgeon RADM(D) A.E. Cadman, honorary dental surgeon to the Queen, in honor of his recent visit to the dental center. As director of Naval Dental Services of the Royal Navy, Surgeon RADM Cadman recently spent 3 weeks touring naval dental facilities in the U.S. — PAO, NAVREGDENCEN, Norfolk, Va. ☸

Fleet Marine Force

Corpsmen Are Prepared

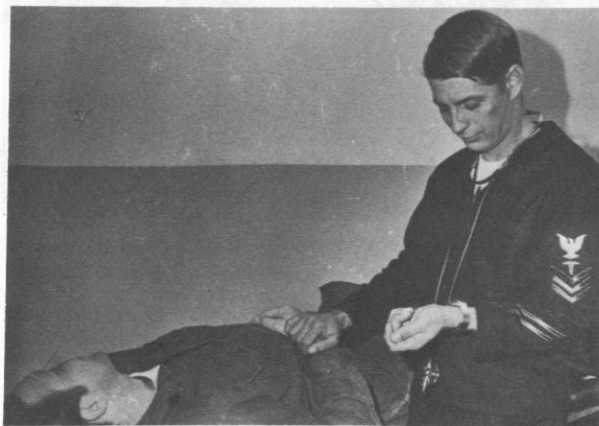
By CAPT D.L. Kelley, MC, USN,* and
ENS C.F. Duncan, MSC, USN,
Naval Regional Medical Center, Camp Lejeune;
and
CDR K.F. Floan, MSC, USN,**
2d Marine Division, Fleet Marine Force
Camp Lejeune, North Carolina

Since the expiration of the Physician's Draft Act, there has been a critical shortage of medical officers available for assignment to the Fleet Marine Force (FMF). To help ease this situation, a local training program to prepare selected hospital corpsmen to assume increased responsibilities in patient care has been instituted by the 2d Marine Division, FMF, using the facilities and medical expertise of the Naval Regional Medical Center (NAVREGMEDCEN) Camp Lejeune, N.C. The 2-phase program is directed by CAPT D.L. Kelley, MC, USN, chief of the Surgical Service, and coordinated by HM1 Charles E. Quinn, USN.

TRAINING PHASE

During the training phase of the Camp Lejeune program, selected senior hospital corpsmen from the 2d

Marine Division, FMF, are assigned for a period of 4 weeks to temporary duty under instruction at the NAVREGMEDCEN Camp Lejeune. Each corpsman works with a medical officer in selected clinics throughout the medical center, learning to conduct physical examinations, evaluate symptoms and diagnostics, appraise



EXPANDED ROLE.—HM1 E. Houch examines a patient at NAVREGMEDCEN Camp Lejeune, N.C. He is one of a select group of hospital corpsmen locally trained for FMF support.

*CAPT Kelley is now a member of the staff at NAVREGMEDCEN Philadelphia, Pa.

**CDR Floan has retired since this article was submitted for publication.

The opinions or assertions expressed herein are those of the authors and are not to be construed as official, or reflecting the views of the Navy Department or the naval service at large.



ALL WRAPPED UP.—HM1 M. Neas is wrapped up in his work at NAVREGMEDCEN Camp Lejeune. After four weeks of intensive training at the medical center, he contributed to FMF medical support.

results of laboratory and radiologic studies, and establish a working diagnosis. Instruction is accomplished on a one-to-one basis between physician and corpsman in a working situation, and the corpsman is allowed to demonstrate his individual skill under close supervision. Corpsmen also attend lectures given by surgeons, cardiologists, radiologists, and internists. Ample opportunity is provided for the trainees to demonstrate the practical application of their knowledge and skill.

During the practical training portion of the program, students work for a total of 160 evening hours in the Outpatient Clinic, under the direct supervision of the medical officer on duty. The trainees perform the initial screening of each patient in the clinic to determine the patient's problem and the necessity for further examination by the medical officer. This practice improves health care delivery in 3 ways: patient waiting time is decreased, the medical officer is given more time to spend with individual patients, and patients learn to accept and trust the health care provided by Navy paramedical personnel. The new expertise acquired by the



CORPSMEN VIEW CULTURES.—As part of a local program to further train hospital corpsmen, LCDR T.A.P. Golden, MC, USNR (left) teaches trainees how to read a dermatology culture. Students are HM1 D. Burt (standing) and HM1 G. Mosion.



HISTORY RECORDER.—Selected hospital corpsmen relieve physicians of many administrative duties. Here HM1 R. Toy checks a patient's medical history for accuracy and completeness.

students further increases their effectiveness in assisting patients when they return to their former assignments.

FUNCTIONAL APPLICATION

After completing this local training, each corpsman is evaluated on the basis of his individual performance during the 4-week period. The trainees may then be reassigned to a unit which does not have a medical officer, or assigned to temporary duty at NAVREGMED-CEN Camp Lejeune. These corpsmen conduct routine and emergency sick call, administer the preventive medicine program for their unit, organize medical-training programs, and perform other administrative duties.

The concept of patient care by hospital corpsmen is not new to the naval service. The Navy has for decades sent ships to sea without physicians, and there exists a vital body of hospital corpsmen officially qualified for independent duty assignments. Future plans are already being considered to provide highly sophisticated back-up for paramedical personnel by integrated 2-way communications systems which will transmit professional advice from experts who are located at naval medical centers.

PROGRAM EVALUATION

In Feb 1973 the product of this abbreviated training program was first tested during field exercise *Alpine Warrior*, conducted in northern New York State. Participating in the exercise was the 2d Marine Regiment, 2d Marine Division, from Camp Lejeune; the regiment consisted of two 2d Marine Division battalions, with one additional reserve battalion from the 4th Marine Division.



APPRAISAL.—Hospital corpsmen learn to appraise results of selected radiologic tests. Here LCDR A. Arnold, MC, USNR (left) discusses orthopedic X-ray studies with HM1 T. De Rouville (center) and HM1 J. Robinson (right).



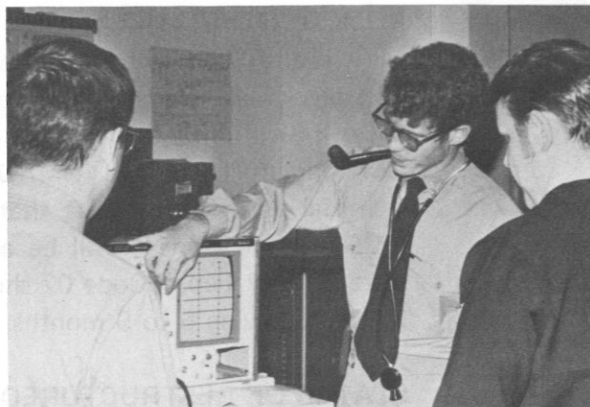
A HEART-BEAT AWAY.—HM1 G. Mosion plays the role of patient as CAPT V.L. Stotka, MC, USN demonstrates techniques of physical examination. Engrossed in the lesson are (left to right): HM1 J. Robinson, HM1 T. De Rouville, HM1 T. Jakubizak, and HM1 D. Burt.



SOFT TOUCH.—HM1 T. De Rouville gently prepares a young patient for an incision and drainage procedure.

Each of these 800-men battalions is normally staffed with one medical officer during deployment. During the *Alpine Warrior* exercise, however, one medical officer was attached to regimental headquarters, and each battalion was staffed by two corpsmen who had been trained at NAVREGMEDCEN Camp Lejeune to function independently. Under this arrangement, no problems were encountered in providing patient care at the battalion sick call.

The trainees also participated in the *Solid Shield* field exercise in May 1974, conducted at Camp Lejeune. During this exercise, 143 casualties received their initial



CHECK EQUIPMENT.—LT J.A. Leinicke, MC, USNR explains some of the basic points in operating equipment used for cardiac resuscitation to HM1 D. Burt (right) and HM1 G. Mosion (left).



MAN ON THE SPOT.—In an emergency the hospital corpsman is usually the first to receive the victim. Here HM2 P. Hudson renders first aid to an injured patient as a routine part of the day's work.

medical evaluation and treatment from these additionally trained hospital corpsmen. Evaluation reports for *Solid Shield* reveal that the corpsmen did an excellent job of caring for these patients.

The results of these 2 field exercises indicate that the Camp Lejeune training program, although limited in scope, was effective in meeting the local needs of the FMF.

Comment

Expedience often requires that Medical Department personnel provide a custom-tailored method of satisfying their own local requirements. The ultimate objective is to improve responsiveness in support of the particular operating forces which they serve. There is seldom sufficient time or resources to construct and develop some intricate system for local implementation. The emphasis is put on getting the job done well, right here and now, using whatever is immediately available. The success of the project rests with the ingenuity, imagination, and capability of those on the scene.

The above report describes such an endeavor. It should not be confused with official naval physician assistant training programs or independent-duty NEC classification, for which extensive formal prerequisites must be satisfied at the Bureau level.—Ed. 🇺🇸

BUMED REORGANIZATION

A recently appointed board will implement BUMED reorganization as rapidly as possible. Main elements of the reorganization are the creation of the Health Sciences Education and Training Command (HSETC), the Naval Medical Research and Development Command (NMRDC), and BUMED codes 5, 7, and 02.

Initial estimates indicate that the moves necessary to complete the HSETC, NMRDC, and Code 5 will be accomplished by early Feb 1975. Code 41 should shift in early Feb. Code 02 should be initiated by mid Feb, growing to full size in the following 6 to 9 months. Code 7 should be created in Jul 1975.

STATUS OF RESTRUCTURED RESERVE

The entire Naval Reserve has been restructured into a contingency response force. Each of 39 Reserve programs and subprograms is now supervised by a program sponsor. The more than 100,000 Reservists have been redistributed into small, trained units responsible for accomplishing specific missions during mobilization.

The BUMED-sponsored Medical Program consists of 80 units which will augment the staff of Navy medical facilities during mobilization, or replace active-duty personnel who are deployed. There are billets for 480 medical officers, 320 dental officers, and 8 preventive medicine units. Whenever possible, units will drill in a hospital environment, preferably at the medical facility which they are designated to support. (See U.S. NAV MED 64:16-18, Nov 1974.)

IMPACT OF OSHA

New regulations concerning federal agency implementation of the Occupational Safety and Health Act of 1970 became effective 1 Nov 1974. By 1 Jan 1975 the Secretary of Defense must submit to the Secretary of Labor a list of the names, addresses, and average personnel strength of all military "establishments." All naval activities are involved, including those with no civilian personnel.

Medical input will be combined with safety information before being forwarded to DOD. (Currently, there is no designated safety sponsor in OPNAV.)

SHORTAGE OF FLIGHT SURGEONS

There will be a flight surgeon shortfall of approximately 42.8% by 1 Jul 1975. The problem is most acute in the junior officer ranks, with a shortfall of 51.1% for LTs and 68.2% for LCDRs. As the number of flight surgeons on active duty decreases, the remaining officers must spend more time in preventive and occupational medicine duties. General medical officer duties previously carried out by flight surgeons will have to be met by other personnel.

Flight surgeon assignments will be in accord with priorities: carrier aircraft wings and Marine air groups, isolated overseas air stations, helicopter wings, antisubmarine warfare and patrol wings, training wings, retraining air groups, and other staff billets.

AEROMEDICAL SAFETY OPERATIONS

Under a new Aeromedical Safety Operations (AMSO) Program, a pool of specially trained, experienced flight surgeons and aerospace physiologists will be

assigned to environmental and preventive medicine units (EPMUs) at Norfolk, Va., and San Diego, Calif. The officers will travel in their designated areas to provide services in support of aircraft accident prevention and investigation, and consultation services in aerospace medicine to the line and to junior flight surgeons in the area.

PROGRESS IN DENTAL RESEARCH

Recent developments announced by the Dental Research Institute include:

- A study of caries- and restoration-free Navy recruits has provided the 1st evidence in humans strongly implicating Streptococcus mutans in the formation of dental caries. A vaccine of formalin-killed bacteria has been effective in preventing colonization of this organism in the oral cavity.
- The healing sequence of mandibular segmental bone grafts in dogs has been studied by means of ^{99m}technetium uptake to determine the optimum immobilization time for mandibular fractures. The radioisotope is picked up in areas of active calcification, and can be detected in healing sites by a gamma camera. In comparison studies, radioisotope scan and biopsy techniques have provided more accurate evaluation of actual healing than radiographic studies. With the new methods of evaluation, it may be possible to reduce the time required for hospitalization and fixation of mandibular fractures.

MEDICAL CONTINGENCY REQUIREMENTS STUDY

Initiated in Sep 1974 with BUMED Code 52 as project manager, the MEDCON Study will develop a model or formula for determining Navy medical contingency requirements. This formula will be adaptable to an automated data processing system in the future, and will reflect the process of determining contingency requirements. The system developed will allow for continuous updating, and for evaluation and simulation of proposed options; it will also support BUMED planning, programming, and budgeting.

The study will be developed in coordination with CNO and the Commandant of the Marine Corps, who will provide scenarios for which BUMED must supply a contingency response.

The BUMED planning policy for evacuation of combat casualties is currently under close examination, to determine whether medical personnel requirements in the combat zone can be reduced without significant loss of combat effectiveness. Conservation of fighting strength, and maintenance of the lowest possible morbidity and mortality rates remain the goals of contingency planners.

TAX RELIEF FOR MEDICAL SCHOLARSHIP STUDENTS

Public Law 93-483 of Nov 1974 authorizes medical students on military scholarships to exclude from their gross income amounts received as scholarship stipends in calendar years 1973, 1974, and 1975. Anyone who paid income tax on the \$100 per month stipend received during 1973 should file an amended return for that year, excluding this amount from their gross income and requesting a refund. Use tax form 1040X to file the amended return. ☛

THE 1974 ORAL HEALTH WORKSHOP

A Preventive Dentistry Program for Children

By CAPT L.R. Pistocco, DC, USN*

and

LT D.T. Sheridan, DC, USNR**

For more than a decade, the Navy Dental Corps has conducted an organized program of preventive dentistry and dental health education for adult military personnel. Similar programs for all eligible dependent children have become available during the past 8 years. There has been a significant reduction in dental disease among Navy families as a result of these efforts.

The 1974 Oral Health Workshop for Children, sponsored by the Dental Department of the Naval Construction Battalion Center in Davisville, R.I., was designed to introduce and evaluate several new preventive dentistry concepts, and to reinforce previously successful procedures. Dental disease control programs for authorized dependent children of the Davisville military complex have been conducted annually since 1967, during National Children's Dental Health Week. Early programs were based on self prophylaxis rather than professional prophylaxis, and because of the limited manual dexterity of very young children, no one under the age of 6

years was considered eligible to participate. All programs were closely coordinated with the local civilian dental community.

EXPANDED PROGRAM

Beginning in 1971 the program was considerably expanded. All young dependents from 4 to 21 years of age were encouraged to participate. Each participant was instructed individually in plaque-control procedures and received a complete prophylaxis with stannous fluoride paste, topical application of aqueous stannous fluoride, and bitewing radiographic examination; daily use of an approved fluoride dentifrice (Navy 3-Agent Cariostasis)[†] was recommended. The mothers were also instructed in dental-disease control, and were invited to observe plaque-control procedures while younger children were being treated. Each child received a complete preventive dentistry kit containing disclosing tablets, 0.007-inch brush, mouth mirror, approved dentifrice, and unwaxed floss, as well as selected educational materials concerning fluoride, plaque, and diet.

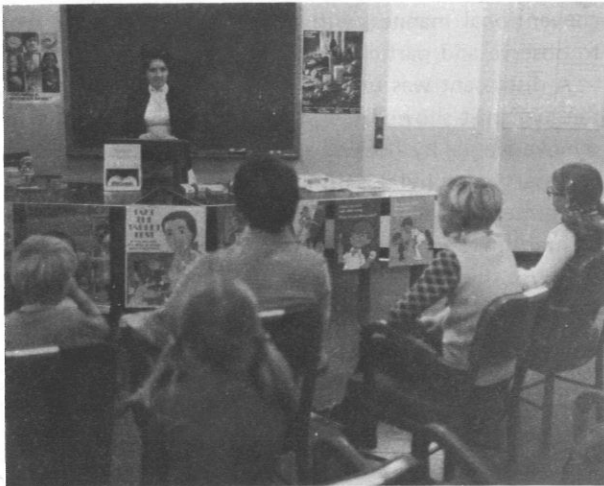
*Senior dental officer, Dental Department, Naval Construction Battalion Center, Davisville, R.I. 02854.

**Dental officer, Naval Mobile Construction Battalion Center Seventy-One, Davisville, R.I.

The opinions and assertions contained in the above article are those of the authors and do not necessarily represent official views of the Navy Department or the naval service at large.

References to commercial supplies and sources should not be construed to imply product endorsement by the U.S. Navy or the naval service at large.

[†]Scola FP and Ostrom CA: Clinical evaluation of stannous fluoride when used as a constituent of a compatible prophylactic paste, as a topical solution, and in a dentifrice in naval personnel. II. Report of findings after two years. JADA 77:594, Sep 1968.



BRUSHING-UP.—Mrs. Virginia Amoroso, dental disease control therapist, reviews the elements of dental disease for young patients during the 1974 Oral Health Workshop at the Naval Construction Battalion Center, Davisville, R.I.

In conjunction with these annual preventive treatments, dental health education programs were conducted in 4 elementary schools located within or near the base housing area in Davisville. Dental disease control was incorporated as an integral part of all prenatal and postnatal clinics conducted on the station, and dental health information was regularly disseminated through the base newspaper and at local Parent-Teacher Association meetings.

Although all these programs were technically effective, we believed that more could be accomplished. In designing the 1974 Oral Health Workshop, we took a sharp look at the less effective features of previous programs for children. We also carefully analyzed current preventive programs for active-duty military personnel, noting how difficult it was to produce sustained behavioral change in the oral hygiene habits of older individuals.

We concluded that our previous programs had not placed enough emphasis on effective education; in particular, the vital first 4 years of life had been neglected. We also felt that the involvement of mothers in previous programs had been too tangential, and that our efforts to control dental disease within the family unit lacked cohesiveness. We therefore decided to focus on the concept that dental disease prevention must begin at birth, and that the mother must be the prime motivative force in the program. Our planning was supported by the published opinions of experts in health-care education who stressed that programs designed to reach preschool children can have far-reaching lifelong cumulative effects. If diet and nutritional control begins at birth, and if fluoride and plaque control begins with the eruption

of deciduous teeth, a child may not develop poor dental hygiene habits which must later be corrected.

A FAMILY AFFAIR

The theme of the 1974 Oral Health Workshop was, "Dental Disease Prevention Is a Family Affair." Designed to supplement and complement existing programs in local schools, this annual workshop views the mother as the single most important element in the dental well-being of her child; her active involvement is essential to success. Full advantage of the maternal contribution was taken during the 1974 program, which was also extended to include expectant mothers and dependent wives. All eligible, dependent children were included, regardless of age.

The program began in Jan 1974, with sessions conducted 2½ days a week for 16 weeks. Appointments were scheduled by family units and 90-minute sessions commenced every half hour. Lectures and family participation were featured during the first 30 minutes; chairside instruction took place during the final hour. Appointments were made by phone, taking care to record the mother's name along with the first names and ages of the children, the rate or rank and unit of the sponsor, and the home phone number.

Individual packages of pamphlets on dental disease control, and supplies were prepared for each parent and child. Each package contained a 13-page brochure, written and produced locally, which described the causes of dental disease, and explained how lifelong oral health could be achieved through prevention. The brochure explained conventional aspects of disease control, provided information on general nutrition and the 4 basic food groups, and offered a list of noncariogenic snack



HELP PREVENT CAVITIES.—Dental assistants Paula Vadney (left) and Lynn Normandin use visual aids to explain how fluoride, bacterial plaque control, and proper nutrition can help prevent dental disease.



KNOW-HOW.—Cathy Taylor learns the correct way to brush her teeth from student hygienist Susan Davenport. The workshop staff encourages children to develop good oral hygiene habits.

substitutes. Additional literature about brushing, flossing, fluoride, and diet was included in each package, along with a dental disease control kit containing a toothbrush, floss, a disclosant, a mirror, and dentifrice. Each parent's package contained a subjective questionnaire to help us determine the effectiveness and acceptability of the workshop, and supplementary educational material.

Two thousand patients were seen during the 16-week workshop, with an average of 6 to 8 patients attending each 90-minute session. The program was conducted primarily by dental auxiliary student volunteers from the Department of Dental Hygiene, University of Rhode Island, who accomplished most of the chairside education and cariostasis. Dental assistant students from Rhode Island Junior College helped provide lectures, and acted as coordinators during the treatment phase. Military dental technicians participated when student hygienists were not available. Navy dental officer participation was limited to examinations requiring 10-15 minutes each session.

TREATING THE VERY YOUNG

We felt it was essential that even very young children attend and actively participate in the workshop. Since we wanted the treatment to be a pleasant, rewarding, and nontraumatic experience, we introduced each child to the dental chair by first giving him a "ride." If the child enjoyed the ride, and seemed willing to participate in the program, the entire preventive procedure was completed in the dental chair in the

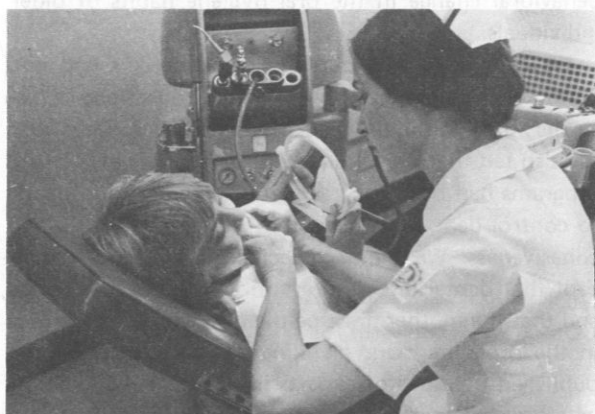
conventional manner, with the child's mother present to observe and participate.

A disclosant was used to demonstrate plaque. Next, the hygienist showed the child and his mother how to remove plaque by flossing and sulcular brushing. When necessary, prophylaxis using dilute fluoride pumice was performed to acquaint the child with the dental armamentarium, and to remove stain. An aqueous, topical, stannous fluoride solution was then applied. Ordinarily the hygienist performed the entire cleaning procedure, although the mother was allowed to brush her child's teeth and, occasionally, to apply fluoride under the hygienist's direction. Sometimes the mother sat in the dental chair, holding her child to be treated in her lap.

Most of the children participated eagerly in every area of the workshop, especially if older brothers or sisters were also being treated. We frequently found that the child who was allowed to watch his mother being treated was a more willing and cooperative patient, when his mother watched *him* being treated.

DENTAL DISEASE CONTROL TECHNIQUES

For all but very young children, the conventional chairside-treatment program consisted of disclosing plaque, demonstrating plaque-control procedures on a model, observing and correcting patients in applying plaque-control measures, and redisclosing. Oral prophylaxis and cariostatic treatment were accomplished using pumices, liquid topical fluoride application, and a fluoride dentifrice; bitewing radiographic examinations were also done. Mothers were advised if their children required definitive treatment to correct existing dental disease, and the examining dental officer answered any questions. Existing or potential orthodontic problems



FLOSS AWAY TOOTH DECAY.—Student hygienist Eileen Allan demonstrates the proper use of dental floss for Judy Taylor. Chairside instruction was an important part of the 1974 Oral Health Workshop.

DON'T GIVE PLAQUE a GHOST of a CHANCE BRUSH and FLOSS DAILY!



NATIONAL CHILDREN'S DENTAL HEALTH WEEK

National Children's Dental Health Week will be observed 2-8 Feb 1975. By agreement with Harvey Famous Name Comics of New York City, the cartoon character Casper, the Friendly Ghost will be named honorary chairman for the week-long observance. Instantly recognized by many youngsters, Casper should provide strong support for this year's theme, "Don't Give Plaque a Ghost of a Chance."

Materials to help plan a National Children's Dental Health Week program are available without charge from: American Dental Association, Bureau of Dental Health Education, 211 E. Chicago Ave., Chicago, Ill. 60611.

Reports and photographs of programs may be submitted to this same address before 15 Mar 1975 for possible use in the American Dental Association's annual evaluation of the week's activities.

U.S. Navy Medicine also welcomes photographs and reports of National Children's Dental Health Week observances at Navy dental facilities. Share your ideas and experiences with your colleagues, and help spread the story of good dental care to the entire Navy family. 🦷

Because we felt mothers could not supervise and perform plaque-control procedures for their children if they neglected to do so for themselves, we taught the mothers how to control their own dental disease, and gave each a prophylaxis and cariostatic treatment. Dental examinations were limited to general observations in areas of obvious need, since we considered the diagnosis and treatment of adults to be beyond the scope of our program.

DISEASE CONTROL THERAPIST

One key figure in the workshop was Mrs. Virginia Amoroso, the dental disease control therapist. A mature, knowledgeable, highly motivated civilian dental assistant assigned to the Naval Construction Battalion Center, Mrs. Amoroso is highly trained in dental disease control procedures and methodology. She conducted the lecture portion of the workshop, tailoring the presentation to the individual needs of each audience, and observing participant reactions to various approaches.

Mrs. Amoroso introduced patients to the dental disease process through a series of posters placed on the walls of the lecture area. Based on the animated film "Trigger Foods," which was shown as part of the program, the posters introduced program participants to bacteria, plaque, carbohydrates, acid, and fluoride, describing how each was related to caries and periodontal disease. "Care of Children's Teeth" was then shown to children under the age of 10 years; this film stressed the importance of parental supervision in the proper care of the children's teeth, and demonstrated proper brushing and flossing techniques. "Flossing and Brushing," which emphasized plaque control techniques and their relationship to dental disease, was shown to more mature audiences.*

Next the patients studied the plaque control armamentarium, and watched plaque control procedures being carried out on a model. Films and posters were then used to illustrate the need for a well balanced diet; cariogenic foods, snacks, and noncariogenic snack substitutes were discussed in detail, and the participants were encouraged to ask questions. The entire presentation took about 30 minutes.

Materials used in the workshop cost less than 20 cents per patient. Dental care kits were supplied free of charge. Posters were obtained from the National

*Films used in the workshop ("Care of Children's Teeth," "Flossing and Brushing," and "Trigger Foods") were produced by Teaching Films, Inc., Houston, Tex., under the guidance of Merrill G. Wheatcroft, D.D.S., FACD, and George B. Robbins, D.D.S., FACD, The University of Texas Dental Branch, Houston, Tex. The films are distributed by Professional Research, Inc., Los Angeles, Calif.

were discussed, and the value of pit and fissure sealants was described when appropriate. Fluoride supplements were prescribed for young children living in areas without a communally fluoridated water supply. Mothers were also taught how to perform sulcular brushing for any of their children who were under the age of 10 years, and learned to floss the interproximal surfaces of their children's teeth, using the head-to-shoulder technique.

Institutes of Health, the National Dairy Council, and the New England Dairy and Food Council, which also provided most of the printed diet and nutritional material.

ASSESSING EFFECTIVENESS

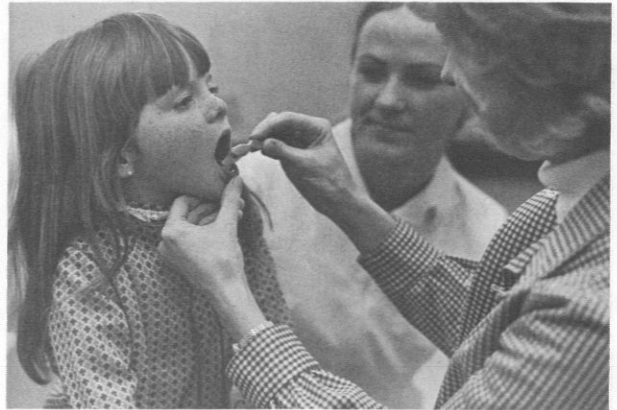
Results of dental examinations were tabulated throughout the program, with caries recorded using three symbols:

- ++ for children in need of immediate dental care;
- + for children with minor dental defects, such as pit and fissure caries not affecting the dentin, incipient interproximal lesions, etc.;
- for children free from dental disease.

Of all the participating children, 58% needed no corrective dental treatment, 18% needed minimal treatment, and 24% needed immediate care. These data are consistent with our 1973 findings, when 61% of the children examined were free of dental disease.

Analysis of the 51% of the subjective questionnaires that were returned revealed generally enthusiastic responses, exceeding our expectations; almost all were overwhelmingly in favor of family participation.

A high percentage of replies indicated that the lecture was a more informative and valuable way to present



OUNCE OF PREVENTION.—During the children's oral hygiene program, Mrs. Jacqueline Wilson (right) demonstrates proper brushing technique on her 4½-year-old daughter, Karri. Student hygienist Paula Corr (center) offers helpful suggestions.

new, useful information than was chairside instruction. But, in fact, none of the lecture material was really new; most of the information had been presented many times previously in other forms — through school group instruction, one-to-one personal teaching, the base news media, and other printed materials. Apparently preventive information is most effective when presented to the entire family in a personal, varied format. ☛

ACCREDITATIONS AND GOOD SHOW

Naval medical facilities wrapping up the year with honors include:

► NAVREGMEDCEN Long Beach, Calif., awarded accreditation by the Joint Commission on Accreditation of Hospitals (JCAH), now becomes 1 of more than 5000 general hospitals throughout the U.S., recognized for providing higher quality of patient care than is required for governmental licensure alone.

► Blood Bank, NAVREGMEDCEN Charleston, S.C., awarded accreditation by the American Association of Blood Banks.

► Anesthesiology Residency Training Program, NAVREGMEDCEN San Diego, Calif., achieving a 92.95 percentile rank as compiled by the National Board of Medical Examiners. Based on the scores of program trainees who took the American Board of Anesthesiology written examination in Jul 1970-1974, only 7.05% of all other anesthesiology training programs placed above, and 91.95% placed below the program at San Diego. ☛

SCHOLARS' SCUTTLEBUTT



At this time of year, medical students are seriously engaged in making plans for their future careers in medicine, and are concomitantly investigating and evaluating the graduate training program for which they will be applying in just a few short months. Along

with students everywhere, our Navy scholars are facing those serious considerations which will affect their future professional careers. We hope that as many of our subsidized students as possible will be able to realize their training goals in the Navy Graduate Medical Education Program.

At present in the Navy, there are critical shortages in the specialties of anesthesiology, family practice, pathology, and radiology. This shortage will continue into the foreseeable future. A career choice in one of these specialties offers many opportunities for training, and for choice of assignment upon completion of training. It is suggested that our Navy scholars obtain clerkships in these specialties as early in their medical school curriculum as possible. Early experience in these specialties should help our students to judge the extent of professional satisfaction which they may anticipate in the suggested areas of specialization.

In the February issue of *Scholars' Scuttlebutt* we will print an updated list of the first-year Graduate Medical Education Specialty Program positions (G-1) which will be offered to medical students in naval hospitals during the 1976-1977 training year. Additional information on the application process will also be sent to our students.

An updated list of the names and phone numbers of naval hospital and Bureau representatives, whom you may contact for further information on medical education, appears in Figure 1.

Names of medical education assistant directors at various naval hospitals are provided below as contacts for further information concerning the program at their respective hospitals:

LOCATION	TELEPHONE	CONTACT
*NRMC Charleston, S.C.	(803) 743-5670	CDR R. Higgins, MC, USN
*NRMC Camp Pendleton, Calif.	(714) 725-3310	CDR J.W. Norton, MC, USN
*NRMC Jacksonville, Fla.	(904) 722-2201	CDR J.C. Baggett, Jr., MC, USNR
*NH Pensacola, Fla.	(904) 452-4411	LCDR J.L. Wilson, MC, USN
NRMC Portsmouth, Va.	(804) 397-6541	CAPT J.P. Collier, MC, USN
NRMC San Diego, Calif.	(714) 233-2022	CAPT C.R. Sargent, MC, USN
NRMC Oakland, Calif.	(415) 639-0111	CAPT V.L. Goller, MC, USN
NNMC Bethesda, Md.	(202) 295-1490	CAPT R.J. Van Houten, MC, USN
NRMC Philadelphia, Pa.	(215) 755-8232	CDR J.F. McGrail, MC, USN

Contacts at the Bureau of Medicine and Surgery, Washington, D.C. are:

Mr. C.B. Mohler	(202) 254-4339
CAPT W.M. McDermott, Jr., MC, USN	(202) 254-4280
CAPT S. Barchet, MC, USN	(202) 254-4279

*Family Practice programs only.

Figure 1.—Helpful Contacts for Information on Medical Education (Updated)

A list of telephone numbers for the Program Directors at our naval hospitals, arranged by specialties, is shown below in Table 1. This list identifies the specific specialties which we will offer. Start to plan now: contact them; arrange interviews; and whenever possible, serve

a clerkship. Let the Program Director get to know you, for it will increase your chance of selection.

Table 2 represents a continuation of the list of our subsidy students located at various schools, publication of which commenced with the Nov 1974 issue.

TABLE 1
GRADUATE MEDICAL EDUCATION SPECIALTY PROGRAM DIRECTORS

ANESTHESIOLOGY

Bethesda, Md.	(202) 295-1490
Oakland, Calif.	(415) 639-0111
Philadelphia, Pa.	(215) 755-8245
Portsmouth, Va.	(804) 397-6541
San Diego, Calif.	(714) 233-2022

CAPT Robert J. VAN HOUTEN, MC, USN
CAPT John L. STEFFENSON, MC, USN
CDR David R. DAVIS II, MC, USN
CAPT Richard H. NORTON, MC, USN
CAPT Clyde W. JONES, MC, USN

DERMATOLOGY

Bethesda, Md.	(202) 295-1036
Philadelphia, Pa.	(215) 757-8277
San Diego, Calif.	(714) 233-2022

CAPT William M. NARVA, MC, USN
CAPT Bernett L. JOHNSON, Jr., MC, USN
CAPT Francis M. HIGHLY, Jr., MC, USN

FAMILY PRACTICE

Camp Pendleton, Calif.	(714) 725-3310 Ext. 4327
Charleston, S.C.	(803) 743-6213
Jacksonville, Fla.	(904) 772-2216
Pensacola, Fla.	(904) 452-4302

CDR John W. NORTON, MC, USN
CDR Robert W. HIGGINS, MC, USNR
CDR James C. BAGGETT, Jr., MC, USN
CAPT George C. BINGHAM, MC, USNR

INTERNAL MEDICINE

Bethesda, Md.	(202) 295-0290
Oakland, Calif.	(415) 639-2147
Philadelphia, Pa.	(215) 757-8342
Portsmouth, Va.	(804) 397-6541
San Diego, Calif.	(714) 233-2861

RADM William J. JACOBY, Jr., MC, USN
CAPT John W. DAVIS, MC, USN
CAPT Carl R. BEMILLER, MC, USN
CAPT James W. LEA, Jr., MC, USN
CAPT Edwin D. KAUFMANN, MC, USN

NEUROLOGY

Bethesda, Md.	(202) 295-0016
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CAPT William L. BRANNON, Jr., MC, USN

OBSTETRICS & GYNECOLOGY

Bethesda, Md.	(202) 295-0010
Oakland, Calif.	(415) 639-2361
Philadelphia, Pa.	(215) 757-2239
Portsmouth, Va.	(804) 397-6541
San Diego, Calif.	(714) 233-3850

CAPT Douglas R. KNAB, MC, USN
RADM Robert L. BAKER, MC, USN
CAPT Richard A. BAKER, MC, USN
CAPT Richard T. UPTON, MC, USN
CAPT Billy D. VIELE, MC, USN

OPHTHALMOLOGY

Bethesda, Md.	(202) 295-0070
Oakland, Calif.	(415) 639-2065
Philadelphia, Pa.	(215) 755-8250
San Diego, Calif.	(714) 233-3850

CAPT Lewis H. SEATON, MC, USN
CDR Philip T. BRISKA, MC, USN
CAPT Bernard R. BLAIS, MC, USN
CAPT Douglas G. BOYDEN, MC, USN

GRADUATE MEDICAL EDUCATION SPECIALTY PROGRAM DIRECTORS (Con.)

ORTHOPEDIC SURGERY

Bethesda, Md.	(202) 295-0103	CAPT David Q. WILSON, MC, USN
Oakland, Calif.	(415) 639-2427	CAPT Ira J. WOODSTEIN, MC, USN
Philadelphia, Pa.	(215) 755-8232	CAPT Frederick J. CREMONA, MC, USN
Portsmouth, Va.	(804) 397-6541	CAPT Charles S. LAMBDIN, MC, USN
San Diego, Calif.	(714) 233-3850	CAPT Gerald W. CADY, MC, USN

OTOLARYNGOLOGY

Bethesda, Md.	(202) 295-0024	CAPT Hugh O. DE FRIES, MC, USN
Oakland, Calif.	(415) 639-2065	CAPT Thomas F. MILLER, Jr., MC, USN
Philadelphia, Pa.	(215) 755-8238	CDR Fred J. STUCKER, MC, USN
San Diego, Calif.	(714) 233-3850	CAPT Robert W. CANTRELL, MC, USN

PATHOLOGY

Bethesda, Md.	(202) 295-1010	CAPT Martin J. VALASKE, MC, USN
Oakland, Calif.	(415) 639-2241	CAPT Melvin BOROWSKY, MC, USN
Portsmouth, Va.	(804) 397-6541	CAPT Nicholas A. D'AMATO, MC, USN
San Diego, Calif.	(714) 233-2022	CAPT Calvin F. BISHOP, MC, USN

PEDIATRICS

Bethesda, Md.	(202) 295-0360	CAPT David W. BAILEY, MC, USN
Oakland, Calif.	(415) 639-2374	CAPT James W. HAYES, MC, USN
Philadelphia, Pa.	(215) 757-8223	CAPT William M. BASON, MC, USN
Portsmouth, Va.	(804) 397-6541	CAPT James L. HUGHES, MC, USN
San Diego, Calif.	(714) 233-2022	CAPT John E. SCHANBERGER, MC, USN

PSYCHIATRY

Bethesda, Md.	(202) 295-0016	CAPT Victor M. HOLM, MC, USN
Oakland, Calif.	(415) 639-2261	CAPT Rolf W. STEYN, MC, USN
Philadelphia, Pa.	(215) 757-8203	CAPT Henry J.T. SEARS, MC, USN

RADIOLOGY

Bethesda, Md.	(202) 295-0047	CAPT Charles W. OCHS, MC, USN
Oakland, Calif.	(415) 639-2157	CAPT Miguel NIEVES, Jr., MC, USN
Philadelphia, Pa.	(215) 757-8200	CAPT Henry L. GIARD, MC, USN
San Diego, Calif.	(714) 233-2022	CAPT Quintous E. CREWS, Jr., MC, USN

SURGERY

Bethesda, Md.	(202) 295-1477	CAPT William J. FOUTY, MC, USN
Oakland, Calif.	(415) 639-2017	CAPT Vernon H. FITCHETT, MC, USN
Philadelphia, Pa.	(215) 757-8240	CAPT Stephen J. MUCHA, MC, USN
Portsmouth, Va.	(804) 397-6541	CAPT Joseph T. MULLEN, MC, USN
San Diego, Calif.	(714) 233-2022	CAPT Claude C. ATKINS, MC, USN

UROLOGY

Bethesda, Md.	(202) 295-1240	CAPT Mitchell EDSON, MC, USN
Oakland, Calif.	(415) 639-2441	CAPT Gilbert A. LE BLANC, MC, USN
Philadelphia, Pa.	(215) 757-8317	CAPT Edward C. SACHER, MC, USN
Portsmouth, Va.	(804) 397-6541	CAPT Oran W. CHENAULT, Jr., MC, USN
San Diego, Calif.	(714) 233-2022	CAPT Charles R. SARGENT, MC, USN

TABLE 2
Students Participating in the 1975 Program
(partial list, continued)

<i>Medical School Group</i>	<i>Class of</i>	<i>Medical School Group</i>	<i>Class of</i>
CHICAGO MEDICAL		EMORY	
LERNER, Terrence	'76	BEAL, Eddie	'75
THOMAS, Robert A.	'75	BROWN, Raymond L.	'75
BISSONNETTE, Bruce M.	'75	GIESECKE, Thomas F.	'76
FULROTH, Richard F.	'76	MILLER, Larry K.	'75
		PATTERSON, Leonard	'76
CHICAGO OSTEOPATHIC		ROLE, Philip A.	'76
ADAMS, Clinton E.	'76	SMITH, John C.	'75
BRIGHT, John R.	'77	WARREN, Tony E.	'77
DOYLE, Michael P.	'77	WHITE, John M., Jr.	'77
GREEN, John C.	'77		
HERBIG, Merrie A.	'77		
LITTLE, William L., Jr.	'76	SOUTH FLORIDA	
LYNCH, Michael J.	'76	BRILLI, Richard J.	'76
MC NAMARA, Brian J.	'76	ESTVOLD, Parker G.	'75
MOORE, Thomas H.	'76	GLOVER, Matthew U.	'75
PAPP, Louis A.	'75	HARTLAGE, Randall J.	'75
RONAN, William V.	'76	KERRIGAN, Kenin R.	'75
SENATORE, Peter T.	'75	RECHTINE, Glenn R. II	'75
TRUSEWYCH, Timothy B.	'76	ROBINSON, Bruce E.	'76
WARNOWICZ, Maryanne M.	'75	WEIMERSKIRCH, Eileen M.	'75
		ZABLE, Elizabeth H.	'76
DES MOINES OSTEOPATHY			
AMUNDSON, Dennis E.	'77		
AYMER, Albert L.	'76	MEDICAL COLLEGE OF GEORGIA	
CALLAN, Daniel J.	'77	COOK, Charlotte E.	'77
CASSADAY, Michael A.	'76	DANIELS, Gary M.	'77
EBERT, Edward L.	'75	DIGBY, Donald J.	'76
ELLESON, Dale A.	'75	EWING, Robert C.	'75
FETCHERO, John A.	'77	FREEMAN, Richard A.	'76
FULTON, Brian T.	'75	GASKINS, Ralph E., Jr.	'76
KOSNOSKY, David P.	'75	GREY, Carlile R. III	'76
MAC GREGOR, Paul S.	'76	HOOSE, William C.	'76
MALICK, Jewell E.	'75	HURST, David B.	'77
MALONEY, Martin J.	'76	HUTCHINS, Earl W.	'75
NOVELLY, Norman J.	'75	JARMAN, Robert H.	'75
ORCUTT, Margaret A.	'76	KWIATKOWSKI, Peter F.	'76
PATTERSON, Todd A.	'75	LAWS, William J. II	'75
PORCASE, Frederic F., Jr.	'76	LENTZ, John D. III	'75
PRATT, Allan T.	'76	MC CANN, Louis S., Jr.	'75
RAEBER, Kirk J.	'77	MEGUIAR, Ramon V.	'75
ROPES, Milton B.	'76	RAST, Philip R.	'75
STEFANEC, Frank J.	'75	ROBERTS, Jerry M.	'76
TEDESCO, "J" M.	'77	ROY, Dennis R.	'75
VERMEER, Richard L.	'77	RUNYON, William G.	'77
WAITE, Lawrence W.	'75	SLOMKA, Charles V.	'76
WHITNEY, Harold E., Jr.	'75	SMITH, Larry R.	'76
WURZBACKER, Terrie	'75	YANTIS, Paul L. III	'76

<i>Medical School Group (Con.)</i>	<i>Class of</i>	<i>Medical School Group (Con.)</i>	<i>Class of</i>
UNIVERSITY OF HAWAII		UNIVERSITY OF IOWA (Con.)	
FLORES, Virgilio V.	'77	ENINGER, Larry A.	'75
HANING, William F. III	'75	HOGAN, Kevin P.	'76
ELLIOTT, David L.	'75	HUNT, Wesley S.	'75
FREY, William B.	'75	MC GHEE, James C.	'77
IZSAK, Eugene	'77	MUNYON, Thomas G.	'75
KOLAKOVICH, Thomas M.	'76	NEFF, William R.	'76
KULB, Thomas B.	'77	NELSON, Robert J.	'75
LONG, Ronald J.	'77	SCHUMANN, Thomas L.	'75
ROBINSON, Adam M., Jr.	'76	VANDERPLOEG, James M.	'75
VUDT, William M.	'75		
UNIVERSITY OF ILLINOIS		STRITCH, LOYOLA	
BIRCHFIELD, James W.	'77	BUCKMAN, Robert W.	'75
CONDIE, Scott D.	'75	CARROLL, Carla D.	'76
SHERMAN, Michael R.	'77	HALAS, Francis P., Jr.	'75
		HAWKINS, Harold H., Jr.	'75
INDIANA UNIVERSITY		HILL, Rosa M.	'76
AYERS, Warren V.	'75	MC MILLIN, Kim I.	'76
BORDERS, John K., Jr.	'75	SALINAS, Ana M.	'75
BROSHEARS, John R.	'76	SLADEK, Gary G.	'76
BROWNING, Mark D.	'77		
DAVIS, Alan C.	'75	NORTHWESTERN	
UNIVERSITY OF IOWA		BITTERLY, Thomas J.	'75
BARKHOFF, Rise L.	'77	CELLA, John A.	'76
CHRISTENSON, David D.	'75	FELLENBAUM, Theodore L.	'76
		GIROUD, George M.	'75
		KRIEG, James R.	'75

SPECIAL NOTE

In this note I would like to review briefly with you, our subsidy scholars, one aspect of your support in medical school as provided under the terms of PL92-426. Under the terms of this legislation funds are provided for you to purchase books. It is the intent of this legislation to provide you with the books that are necessary, as stipulated by your school, to fulfill your course requirements. In reviewing the vouchers that are submitted to the Bureau of Medicine and Surgery for reimbursement, it is evident that abuses of the intent of the regulations are developing.

There are indications that some students are purchasing books far in excess of those required to successfully complete a medical school curriculum. It is absolutely unnecessary that a medical student purchase, for example, all of the definitive texts in the subspecialty areas to which he may be briefly exposed; or that he purchase all of the texts in a given field. Some of these texts cost in excess of \$100. Our dollars are limited. Your excesses may prevent some other student from purchasing the necessary texts or, possibly, even from enrolling in our scholarship program.

It is not our intent to suggest that we will not authorize those books which your deans have indicated are required. But, it should be fully recognized that we will not authorize reimbursement for texts which are far in excess of the needs and requirements of a medical student. If you have any questions regarding this policy, check with the program managers at this Bureau prior to making the purchase.



GUIDELINES FOR HUMAN GOALS PROGRAMS

The Chief of Naval Operations has issued a reminder that all Human Goals Programs must be conducted in a military setting. Participants should wear the uniform normally prescribed for the area in which the program is conducted, and personnel should be addressed in accordance with standard Navy protocol.

Sensitivity training or encounter techniques are not authorized, except when used in drug or alcohol rehabilitation programs run by qualified counselors, clinical psychologists, or psychiatrists. Unauthorized programs include those in which:

- A direct attack is made on the character of an individual (as opposed to an honest expression of general likes and dislikes).

- An individual is forced to publicly reveal before a group his personal attitudes, feelings, and innermost thoughts (as opposed to voluntary relating of experiences).

Personnel engaged in Human Goals Programs should set an excellent example in proper grooming and observance of military courtesy. — BUMED Code 1.8

KUDOS TO ANESTHESIOLOGY PROGRAM AT SAN DIEGO

CAPT C.W. Jones, MC, USN, Anesthesiology Program Director at San Diego Naval Hospital, Calif., has been advised that his program was assigned a 92.95 percentile rank as compiled by the National Board of Medical Examiners for the 1974 performance index of residency training programs. Simply stated, it means that 7.05% of the programs placed above that at San Diego, and 91.95% of the programs placed below the Naval Hospital San Diego program.

The percentile rank is based on the actual scores received by the Program's trainees who took the written examination of the American Board of Anesthesiology in July, 1970-1974. It is a continuing 5-year average score computation for trainees taking the examination for the first time, who have received 18 months' (or more) training at a single institution.

The excellent performance index achieved by the graduate medical training program in anesthesiology at San Diego Naval Hospital illustrates the typical high standards of Navy medicine, and the very capable physicians responsible for that demonstrated excellence. Hearty congratulations to CAPT Jones and his staff. 8

NAVY ENVIRONMENTAL HEALTH EFFECTS LABORATORY

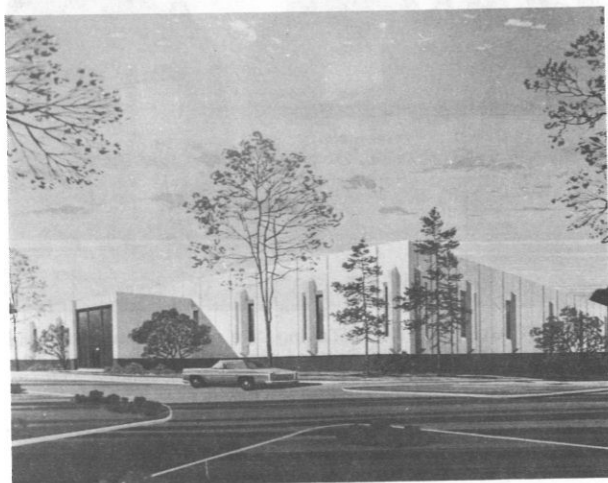
Groundbreaking ceremonies for the Navy Environmental Health Effects Laboratory were held at the National Naval Medical Center (NNMC), Bethesda, Md., on 6 Dec 1974. A part of the Naval Medical Research and Development Command (NMRDC), the new laboratory is expected to be ready for use by Nov 1976.

As the major deep-diving research facility of the Navy Bureau of Medicine and Surgery, the new laboratory will be used by the Naval Medical Research Institute and the Navy Toxicology Unit. It will include a modern, extensive chamber complex, and associated laboratories for biomedical research on diving problems at pressures equivalent to 3,300 feet. The laboratory staff will specialize in the study of physiologic, behavioral, and toxicologic aspects of extended saturation diving at great depths, where cold temperature and high pressure present significant risk.

"We anticipate that the fundamental and applied research to be performed in the Environmental Health

Effects Laboratory, largely with animal models, will provide information of prime value to operations over the next 2 decades in all the armed services, and to the broad sector of the world economy involved in tapping the resources of the seabed," explained CAPT Charles Brodine, MC, USN, CO, NMRDC.

The Environmental Health Effects Laboratory was designed by Sanders and Thomas, Inc., and is being constructed by Edward M. Crough, General Contractor. — PAO, NNMCMC, Bethesda, Md.



UNDER CONSTRUCTION.—The Navy Environmental Health Effects Laboratory, shown here in an artist's conception, is now being constructed at the NNMCMC Bethesda, Md.

GROUNDBREAKING FOR CHASE FIELD DISPENSARY AND DENTAL CLINIC

Groundbreaking ceremonies were held on 25 Oct 1974 at NAS Chase Field, Beeville, Tex., marking the start of construction for a new dispensary and dental clinic. The new facility will function as a satellite of Nav Hosp Corpus Christi, Tex.

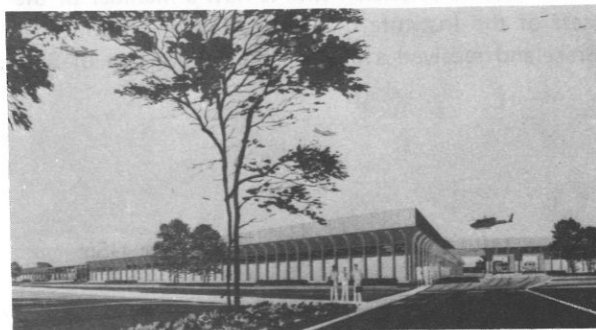
To be constructed of reinforced concrete, precast concrete panels, and structural steel, the building will encompass 31,323 square feet, and will be equipped with a 165-ton, air-conditioning plant. The most modern medical, dental, and laboratory equipment will be installed. Among the notable features of the dispensary are: a 5-bed holding capacity; complete emergency room, obstetrical suite, and X-ray facilities; clinical evaluation and testing facilities; physical therapy capability; laboratories; pharmacy; and examining rooms and office space for 7 physicians. The dental clinic will accommodate 4 general dental operatories, a surgical operatory, a prosthetics operatory and laboratory, and

X-ray and preventive dentistry capabilities. The project also includes a garage for ambulances, a helicopter landing pad, and expansive parking areas.

During the groundbreaking ceremonies, CAPT James E. Turner, MC, USN, CO of the Nav Hosp Corpus Christi said: "The people at Chase will benefit from this dispensary, which will be of the highest quality for people of the highest quality."

State Representative Jon Newton complimented the personnel of Chase Field for the good relationship they had established with Beeville, praising their many contributions to the community through Little League and equal-opportunity programs, as well as sea and air rescue services.

The architectural firm of Wisznia & Peterson in Corpus Christi planned and designed the new facility. A construction contract for \$2,149,500 was awarded to Anchor Constructors, Inc. Project development and construction are under the supervision of Southern Division, Naval Facilities Engineering Command, Charleston, S.C. — PAO, NAS Chase Field, Beeville, Tex.



CHASE FIELD COMPLEX.—A helicopter landing pad, ambulance garage, and expansive parking areas are some of the features planned for the new dispensary and dental clinic that is now being built at NAS Chase Field, Tex.

AMERICAN COLLEGE OF DENTISTS FELLOWSHIPS

Congratulations to 4 Navy dental officers recently inducted into the American College of Dentists in Washington, D.C. The new Fellows are: CAPT William K. Bottomley, DC, USN; CAPT Robert J. Leupold, DC, USN; CAPT Henry J. Sazima, DC, USN; and CAPT Noel D. Wilkie, DC, USN.

By granting Fellowship, the American College of Dentists recognizes individuals who have contributed to the advancement of the dental profession. Fellowship in the College is by invitation, and is bestowed upon only a select few. — BUMED Code 6.

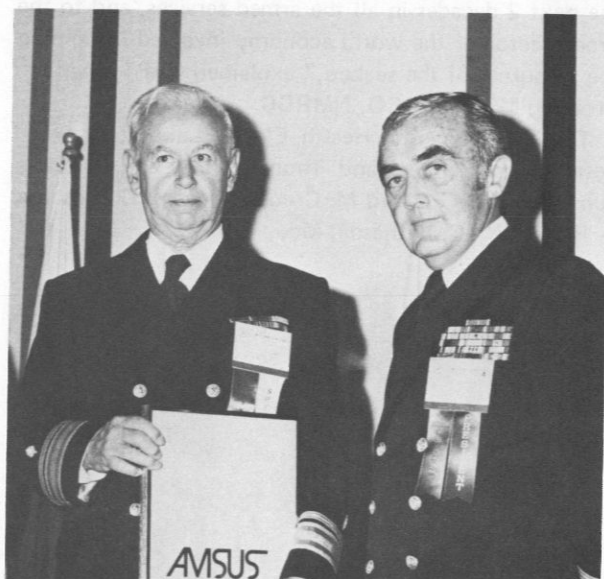
AMSUS AWARD WINNERS

Members of the Navy Medical Department, both past and present, each outstanding in his respective field, were honored during the 81st annual meeting of the Association of Military Surgeons of the United States (AMSUS), held 28 Oct-1 Nov 1974 in San Diego, Calif.

RADM Francis J. Braceland, MC, USNR-R
The William C. Porter Lecture

The William C. Porter Lecture honors the Army COL who was a pioneer in military psychiatry. The lecture was initiated in 1958, and was reestablished in 1968 by Geigy Pharmaceuticals Division, Ciba-Geigy Chemical Corp.

This year's lecture, "Taking Care of the Caretakers," was delivered by RADM F.J. Braceland, a retired Naval Reserve physician who is now a member of the staff of the Institute of Living, Hartford, Conn. Dr. Braceland received a plaque and honorarium of \$500.



THE CARETAKERS.—"Taking Care of the Caretakers" was the title of the William C. Porter Lecture delivered by RADM F.J. Braceland, MC, USNR-R (left) at the 81st annual AMSUS meeting. Navy Surgeon General VADM D.L. Custis, MC, USN (right) presented Dr. Braceland with the plaque and honorarium.

CAPT Bennett L. Johnson, Jr., MC, USN
The James Clarke White Award

This award honors James Clarke White, M.D., a pioneer in the field of clinical and research dermatology. Initiated by Eli Lilly and Co., the prize consists of a bronze plaque and an honorarium of \$500; it is presented to an AMSUS member for outstanding work in clinical or research dermatology accomplished while employed by the U.S. Government.

CAPT B.L. Johnson, Jr., chairman, Department of Dermatology, NAVREGMEDCEN Philadelphia, Pa., was honored for his exceptional contributions as consultant, clinician, and teacher in the field of dermatology. CAPT Johnson has developed a superb dermatology residency training program at his medical center, and is responsible for the Navy's only training program for dermatology technicians.



AWARD-WINNING DERMATOLOGIST.—CAPT B.L. Johnson, Jr., MC, USN (right) holds the James Clarke White Award, presented to him in recognition of his outstanding work in the field of dermatology. At left is VADM D.L. Custis, MC, USN.



AUTHOR, AUTHOR.—VADM D.L. Custis, MC, USN congratulates two medical writers: CAPT V.L. Stotka, MC, USN (left) and LCDR R.P. Wenzel, MC, USNR (center). The officers received the MAJ Louis Livingston Seaman Prize for the best article published in *Military Medicine* during the previous calendar year.



RESIDENT LAUDED.—CDR A.B. Pleet, MC, USN (right), a resident in neurology at the National Naval Medical Center, receives the AMSUS Federal Medical Residents' Award. With him is VADM D.L. Custis, MC, USN, the Navy Surgeon General.

**CAPT Victor L. Stotka, MC, USN
LCDR Richard P. Wenzel, MC, USNR
The MAJ Louis Livingston Seaman Prize**

Made possible through funds donated by the late MAJ L.L. Seaman, a surgeon of the First U.S. Volunteers Spanish-American War, this award consists of a scroll and a \$250 honorarium. The prize is given for a notable article published in *Military Medicine* during the previous calendar year.

This year's prize-winning article was "Malaria in Vietnam (I Corps Sector): Review of 214 Cases Including EEG Patterns on 19 Acutely Ill Patients," which appeared in the Dec 1973 issue of *Military Medicine*. Coauthors were: CAPT V.L. Stotka, chief of medicine, NAVREGMEDCEN Camp Lejeune, N.C.; and LCDR R.P. Wenzel, MC, USNR, assistant professor of medicine and hospital epidemiologist, University of Virginia, Charlottesville, Va.

**CDR A.B. Pleet, MC, USN
Federal Medical Residents' Award**

Initiated by the Purdue Frederick Co. in 1970, this award is given to an outstanding federal medical resident serving in a federal hospital teaching program. The award consists of a plaque and an honorarium of \$500.

A resident in neurology at the National Naval Medical Center (NNMC), Bethesda, Md., CDR A.B. Pleet was honored for original research involving a comprehensive clinical research program on causalgia.

CAPT Emanuel N. Buckley, MSC, USN
The Joel T. Boone Award

This award was established by the AMSUS Executive Council in 1969 as a tribute to the late VADM Joel T. Boone, MC, USN, a former AMSUS president. Reestablished in 1972 by the Ciba Pharmaceutical Co., Division of Ciba-Geigy Chemical Corp., the award consists of a silver plaque and a \$500 honorarium; it is given in recognition of outstanding service to the Association.

CAPT E.N. Buckley is director of the Patient Affairs Division, BUMED Code 39; he received the award in recognition of his unselfish devotion to duty and notable contributions toward the enhancement of the professional stature of military medicine.

RADM Willard P. Arentzen, MC, USN

RADM William J. Jacoby, MC, USN

The Founder's Medal

The Founder's Medal, a scroll, and AMSUS life membership are given annually for outstanding contributions to military medicine and for meritorious service to the Association. This award was established in 1941 to commemorate the Association's 50th anniversary.

Two Navy physicians were honored for their service



BOONE AWARD.—CAPT E.N. Buckley, MSC, USN (left) receives congratulations from VADM D.L. Custis, MC, USN on winning the Joel T. Boone Award.

in developing and coordinating the scientific program for the 81st annual AMSUS meeting: RADM W.P. Arentzen, director and commanding officer, NAVREG-MEDCEN San Diego, Calif., general chairman for the meeting; and RADM W.J. Jacoby, chief of medicine, NNMC, program chairman.



FOUNDER'S MEDAL.—Honored for outstanding contributions to military medicine and for meritorious service to AMSUS were RADM W.P. Arentzen, MC, USN (left) and RADM W.J. Jacoby, MC, USN (right). The two Navy physicians received the AMSUS Founder's Medal, a scroll, and life membership in the Association.

NAVY PHYSICIANS PRESENT AWARD-WINNING OB/GYN PAPERS

Two Navy physicians have received awards for papers presented during the 23rd annual meeting of the Armed Forces Seminar on Obstetrics and Gynecology, sponsored by the Armed Forces District of the American College of Obstetricians and Gynecologists (ACOG), 3-8 Nov 1974 in Washington, D.C.

CDR Donald G. Gallup, MC, USN received the Ortho Award for the best paper on gynecology from a graduate



ORTHO AWARD.—During the 23rd annual meeting of the Armed Forces Seminar on Obstetrics and Gynecology, CDR Donald G. Gallup, MC, USN (right) receives the Ortho Award for best paper in gynecology from a teaching hospital. Presenting the award is MGEN William A. Boyson, MC, USA, chairman of the Armed Forces District of the ACOG. (Photos by HM1 Ken Dougherty, USN.)



RESIDENT'S AWARD.—LT W.K. Murray, MC, USN (left) receives the 2nd prize Hoechst-Roussel Resident's Award for the paper entitled, "Improved Management of the Pregnant Diabetic," written during his residency training with several coauthors. Presenting the award is MGEN William A. Boyson, MC, USA.

training hospital. Sponsored by the Ortho Pharmaceutical Corporation, this award consists of a check for \$250 and a certificate.

CDR Gallup's prize-winning paper, "Carcinoma of the Vagina In Situ — A Study and Review," described a retrospective study carried out on 25 patients treated for vaginal carcinoma at the University of Michigan Medical Center from 1960 to 1973. Currently a fellow at the medical center, Dr. Gallup reported that intra-epithelial carcinoma of the vagina was found to occur post treatment for both carcinoma in situ and invasive carcinoma of the cervix, post hysterectomy for benign disease of the uterus, and as a primary entity. A vaginal cytologic smear led to the diagnosis in the majority of patients, he reported, and biopsies confirmed the diagnosis in all but 4 patients. All positive biopsies were compatible with a diagnosis of vaginal squamous cell carcinoma in situ. Follow-up for all patients revealed 5 recurrences after treatment. Dr. Gallup emphasized the need for continued use of Papanicolaou smears in patients who have had a hysterectomy, regardless of the reason for the operative procedure.

LT W.K. Murray, MC, USN won the 2nd prize Hoechst-Roussel Resident's Award, presented by Hoechst-Roussel Pharmaceutical Inc. for the best papers written during residency training. The prize consists of a plaque and a check for \$150.

Currently a resident in the Department of Obstetrics and Gynecology at NAVREGMEDCEN Oakland, Calif., LT Murray shares authorship of the paper, "Improved Management of the Pregnant Diabetic," with LCDR S.B.



OUTSTANDING SERVICES.—CAPT Douglas R. Knab, MC, USN (right) receives a plaque from MGEN William A. Boyson, MC, USA in recognition of outstanding services as program director for the 23rd annual meeting of the Armed Forces Seminar on Obstetrics and Gynecology, held 3-8 Nov 1974 in Washington, D.C.

Lewis, MC, USN; LCDR D.R. Coustan, MC, USN; CDR J.D. Wallin, MC, USN; and CAPT T.A. Daane, MC, USN. The study was designed to evaluate in an outpatient population the efficacy of rigid control for reducing perinatal mortality to the level observed in a well controlled hospitalized group. Using the parameters of birth weight, infant survival, average blood glucose level, and glucose excursion, study results indicate that pregnant, "brittle" diabetics who are so managed do not differ significantly from normal controls.

More than 1,000 military and civilian Ob/Gyn specialists attended the week-long meeting and seminar. Special programs were available for physicians' wives, who were also invited to attend many of the professional sessions.

CAPT Douglas R. Knab, MC, USN, chairman of the Department of Obstetrics and Gynecology, National Naval Medical Center (NNMC), Bethesda, Md., received a plaque in recognition of his outstanding services as program director for the seminar. — PAO, American College of Obstetrics and Gynecology.

MUST FACILITIES PASS FIRST STATESIDE TEST

The first stateside surgical operation using Marine Corps medical unit self-contained transportable (MUST) facilities was performed on 11 Oct 1974 at Camp Lejeune, N.C., when a Marine sergeant underwent an emergency laparotomy.

A field hospital of the Provisional MUST Company, 2nd Marine Division, had been erected in a parking lot adjacent to NAVREGMEDCEN Camp Lejeune to support the hospital during a planned 5-day power outage. Capabilities established included 2 operating rooms, a central surgical-supply room, recovery area, and sleeping quarters.

Designed to be self-sufficient, the MUST facility generates its own electrical power, providing its own heating and cooling systems, as well as suction and positive pressure outlets. At Camp Lejeune, the water and sewage systems were connected with those of the medical center.

Two more surgical procedures were accomplished in the field hospital before power was restored to the operating rooms in the medical center. The MUST facility was disestablished on 15 Oct 1974.

The success of this effort suggests the feasibility of future use of MUST facilities in support of mass casualties and natural disasters, when the flexibility and mobility offered by the unit could prove most advantageous.

The Provisional MUST Company was commissioned on 2 Apr 1973, and is under the command of LT Richard J. Lindsay, MSC, USN. — PAO, Provisional MUST Company, 2nd Marine Division, FMF, Camp Lejeune, N.C.



MUST FACILITY.—A field hospital of the Provisional MUST Company, 2nd Marine Division, provides support to NAVREGMEDCEN Camp Lejeune, N.C., during a planned power outage. (Photo by PFC Alan Anderson, USMC.)



STATESIDE FIRST.—The first patient to undergo surgery in a stateside Marine Corps MUST facility is wheeled into the field hospital.

NAVY DENTISTS SHOW INTERNATIONAL FLAIR

Among Navy dental officers, the trend in 1974 was definitely international. In Jun 1974, CAPT Dorsey J. Moore, DC, USN, chief of the Maxillofacial Prosthetics Division, Prosthodontics Department, National Naval Medical Center (NNMC), Bethesda, Md., was a featured speaker at the 7th Asian Pacific Dental Congress in Jakarta, Indonesia. Hosted by the Indonesian Dental Association, the Congress attracted nearly 1500 registrants. As an international circuit course lecturer of the American Prosthodontic Society, CAPT Moore discussed "Maxillofacial Prosthetics for Today." While in

Indonesia, CAPT Moore also helped design and participated in a medical/dental seminar on the rehabilitation of maxillofacial disorders.

The 62nd Annual World Dental Congress of the Federation Dentaire Internationale brought 3 Navy dental officers to London as delegates in Sep. RADM A.K. Kaires, DC, USN, CAPT James Enoch, DC, USN and CAPT Henry Sazima, DC, USN also visited facilities of the Royal Army Dental Corps at Aldershot, England.

Meanwhile, a Royal British Navy dental officer was participating in a 2-week indoctrination program at Naval Regional Dental Center, Norfolk, Va. Surgeon Commander David A. Coppock, currently an exchange officer on the staff of the Naval Graduate Dental School at NNMC Bethesda, Md., was also a guest speaker at the professional meeting of Armed Services dental officers in the Tidewater area, held 15 Oct 1974. Approximately 90 military dental officers heard him discuss the practice of dentistry in Great Britain, the Royal British Navy, and the U.S. military services.

CAPT Harold E. Freeburn, Jr., DC, USN was honored for his "outstanding leadership, professional competence, and resourcefulness" as senior dental officer at NATO Base, Keflavik, Iceland. A graduate of the University of Pittsburgh Dental School, CAPT Freeburn received the Joint Service Commendation Medal in recognition of his significant contributions to the accomplishment of the mission of the Iceland Defense Force. — PAOs, NNMC Bethesda, Md.; NAVREGDENCEN Norfolk, Va.; COMICEDEFOR, FPO N.Y. 09571.



JAKARTA MEETING.—CAPT D.J. Moore, DC, USN (left) was a principal speaker at the 7th Asian Pacific Dental Congress, Jakarta, Indonesia. While at the Congress, CAPT Moore conferred with Indonesian medical and dental leaders (left to right): MAJGEN Jusuf, Surgeon General, Indonesian Army; Vice Marshal Sejosjo, Surgeon General, Armed Forces of Indonesia; Dr. Liem Tjing Kiat, director, Indonesian Navy Dental Institute; and Commodore Azhar Zahir, Surgeon General, Indonesian Navy.



LONDON DELEGATES.—Representing the U.S. Navy Dental Corps at the 62nd Annual World Dental Congress of the Federation Dentaire Internationale in London, England, are (left to right): CAPT James Enoch, DC, USN; RADM A.K. Kaires, DC, USN; and CAPT Henry Sazima, DC, USN.



BRITISH VISITOR.—Surgeon Commander David A. Coppock, a dental officer in the Royal British Navy (right), receives a plaque from RADM G.A. Besbekos, DC, USN, director and commanding officer of Naval Regional Dental Center, Norfolk, Va., to mark the completion of a 2-week indoctrination program at the dental center.

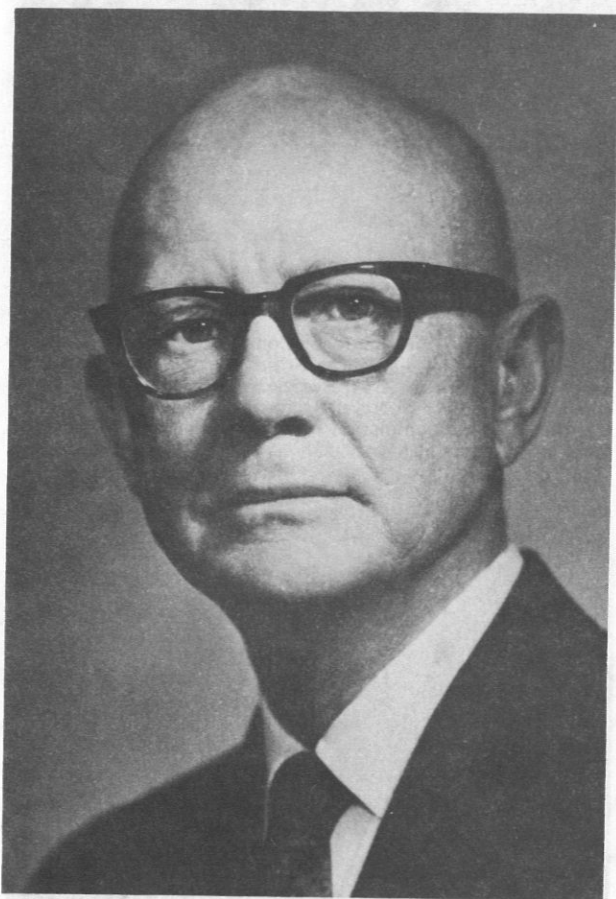


AWARD IN ICELAND.—As his wife looks on, CAPT Harold E. Freeburn, Jr., DC, USN (right) receives the Joint Service Commendation Medal from RADM Harold G. Rich, USN, commander of the Iceland Defense Force.

DR. GRAYBIEL HONORED BY NASA

Ashton Graybiel, M.D., a retired Navy Medical Corps CAPT now serving at the Naval Aerospace Medical Research Laboratory, Pensacola, Fla., received the Exceptional Scientific Achievement Medal from the National Aeronautics and Space Administration in a special Skylab awards ceremony held 21 Nov 1974 at the Marshall Space Flight Center, Huntsville, Ala.

The recipient of many national and international honors, Dr. Graybiel has been the principal investigator for 3 Skylab experiments. He is known for his ongoing research in motion sickness, and originated the "Thousand Aviator" study, one of the oldest longitudinal studies in medical history. This study began with his examination of 1,056 aviators in 1940 and 1941. — PAO, Nav Aerosp and REGMEDCEN, Pensacola, Fla.



HONORED BY NASA.—Retired Navy Medical Corps CAPT Ashton Graybiel, scientific investigator at the Naval Aerospace Medical Research Laboratory, Pensacola, Fla., recently received the Exceptional Scientific Achievement Medal from the National Aeronautics and Space Administration.

NEW BUILDING DEDICATED NAVREGMEDCEN CAMP PENDLETON

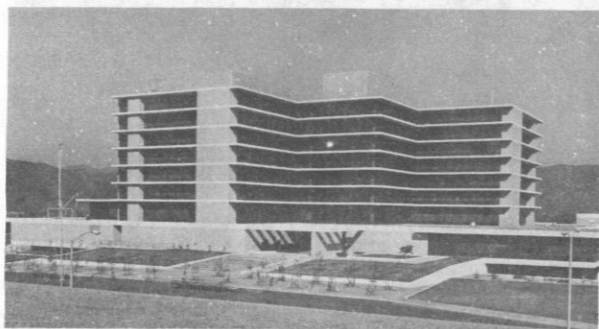
A modern, 9-story, 600-bed naval regional medical center was dedicated at Camp Pendleton, Calif., on 1 Nov 1974, replacing the old naval hospital which had served as the major Marine medical facility on the West Coast since World War II.

Encompassing 427,500 square feet, the completely air-conditioned building holds 200 medical and 240 surgical nursing beds, 15 medical and coronary intensive-care beds, 15 surgical intensive-care beds, 60 neuropsychiatric nursing beds (including a 20-bed closed ward), 40 obstetrical nursing beds, and 30 pediatric nursing beds. In addition, there is space for 11 clinics; laboratory, radiology, food service, and support facilities; and administrative offices. Separate main entrances are provided for outpatients, emergency patients, staff, and visitors.

The building incorporates the most modern technologic advances in communication systems, automated transportation systems for supplies and trash disposal, and a central vacuum system. A nurse-call system electronically connects each patient to a nearby nursing station. There is also a modern central dictation system to facilitate transcribing of patient data for health records.

Special features in the laboratory include: a sequential multiple-analysis computer capable of performing 2400 chemistry tests per hour; a Coulter S blood cell analyzer which can accomplish a complete blood count in 20 seconds; and an automated gamma counter capable of performing radioisotope determinations on 200 blood samples per hour.

The recovery room and both intensive care units feature equipotential grounding systems and isolated power consoles, through which equipment can be connected to monitor patients. A built-in alarm automatically sounds if any discrepancy in a patient's vital signs



CAMP PENDLETON.—This modern, 9-story, 600-bed naval regional medical center building was dedicated at Camp Pendleton, Calif., on 1 Nov 1974.

is detected, or if a piece of equipment is not properly grounded.

One operating room is equipped with a laminar air exchange system which provides 5.6 air exchanges per minute. This room is used for lengthy orthopedic surgical procedures in which the potential for contamination is increased; while working in this room, the operating staff will utilize the bio-vac exhaust system.

All these features are designed to improve each patient's comfort, or to contribute to the excellence of patient care.

NAVREGMEDCEN Camp Pendleton was designed by William L. Pereira Associates, Corona del Mar (architects) and Medical Planning Associates, Malibu (medical planners), to adapt easily to future changes in health care concepts. The medical center will provide support to the Marine Corps Base, Camp Pendleton; Naval Weapons Station, Fallbrook; Marine Corps Air Station, El Toro; Marine Corps Supply Center, Barstow; and the Marine Corps Base at Twenty-nine Palms. The NAVREGMEDCEN commanding officer is CAPT E.D. Loweecey, MC, USN. — PAO, NAVREGMEDCEN Camp Pendleton, Calif. ☘

✠ In Memoriam ✠

James B. Back, M.D., one of the most highly decorated physicians to serve in Vietnam, died on 20 Sep 1974.

Born in 1939, Dr. Back received his undergraduate education at the University of Kentucky, earning admission to Phi Beta Kappa. He received his M.D. degree from Vanderbilt University School of Medicine in 1965, and underwent surgical training at the University of Colorado School of Medicine.

Following commissioning in the Naval Reserve, LT Back trained at the Field Medical Service School, Camp Pendleton, Calif., before joining the 1st Marine Division in Vietnam, where he served from 1967 to 1968. As a result of his service in Vietnam, he was awarded the Navy Cross, Bronze Star with a Combat "V," Navy and Marine Corps Medal, Navy Commendation Medal with Combat "V," Vietnamese Cross of Gallantry, and 2 Presidential Unit Citations.

LT Back then joined the staff of the Neurological Service, at Nav Hosp Camp Pendleton. During his tour there, he was coauthor of 15 published medical articles and 1 medical training film.

Released from active duty in 1969, Dr. Back temporarily engaged in the general practice of medicine in Lexington, Ky., before returning to California to pioneer

the practice of emergency medicine at the San Antonio Community Hospital, Upland.

He is survived by his widow, Yolanda; a son, Jeffery; a daughter, Kathryn; and his mother and sister.

Those who were associated with Dr. Back during his brief but exemplary career were honored to have worked with such an astute clinician and pleasant colleague. — (By courtesy of CAPT Fred E. Jackson, MC, USN [Ret.], 4933 Conejo, Fallbrook, Calif. 92028.)



James B. Back, M.D. (1939-1974)

CDR Zoe P. Gilmore, NC, USN (Ret.), who served 21 years in the Navy Nurse Corps, died 5 Sep 1974 in Cheverly, Md., at the age of 54 years.

Born 5 Jul 1920, CDR Gilmore received her B.S. degree in nursing from Duke University, Durham, N.C.; she earned an M.S. degree from St. John's University, Jamaica, N.Y., in 1961.

Commissioned as ENS in May 1944, her nursing career included professional assignments in naval medical facilities at Portsmouth, Va.; Jacksonville, Fla.; San Diego, Calif.; Yokosuka, Japan; St. Albans, N.Y.; Bethesda, Md.; and NAS Argentia, Newfoundland. From 1946 to 1947 she taught at the U.S. Navy School for Native Nurses in Guam. Her last assignment before disability retirement in 1965 was at Nav Hosp Great Lakes, Ill.

CDR Gilmore held the following medals: American Campaign, Asiatic-Pacific Campaign, WWII Victory, Korean Service, United Nations Service, and National Defense Service.

As the Surgeon General's representative, RADM Alene B. Duerk, NC, USN, director of the Navy Nurse Corps, attended the funeral services which were followed by interment of the late CDR Gilmore with full military honors, at Arlington National Cemetery on 10 Sep 1974. ☘

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LEGION OF MERIT TO RADM SPARKS

RADM Henry A. Sparks, MC, USN, CO of NAVREGMEDCEN Oakland, Calif., has been awarded the Legion of Merit for exceptionally meritorious conduct in the performance of outstanding service as CO of Naval Medical Research Unit (NAMRU) No. 3, Cairo, Arab Republic of Egypt, from Jul 1970 to May 1974.

As director of the scientific programs of NAMRU No. 3 and the NAMRU No. 3 detachment in Addis Ababa, Ethiopia, RADM Sparks' competent, imaginative, and resourceful leadership helped broaden the research and development base of projects concerned with infectious disease. RADM Sparks also served as physician to the Embassy Health Unit, and was a key member of the U.S. Interest Section. His excellent communication and rapport with officials of the Arab Republic of Egypt and the U.S. Interest Section were influential assets in obtaining a 25-year lease extension for NAMRU No. 3. — PAO, NAVREGMEDCEN Oakland, Calif.



CHEERS AND CONGRATULATIONS.—Good humor is the order of the day as RADM Henry A. Sparks, MC, USN (left), CO of NAVREGMEDCEN Oakland, Calif., receives the Legion of Merit for outstanding service as CO of NAMRU No. 3, Cairo, Arab Republic of Egypt (Jul 1970-May 1974). Presenting the award, and sharing the high spirits of the occasion, is RADM Martin D. Carmody, USN, commandant of the 12th Naval District.

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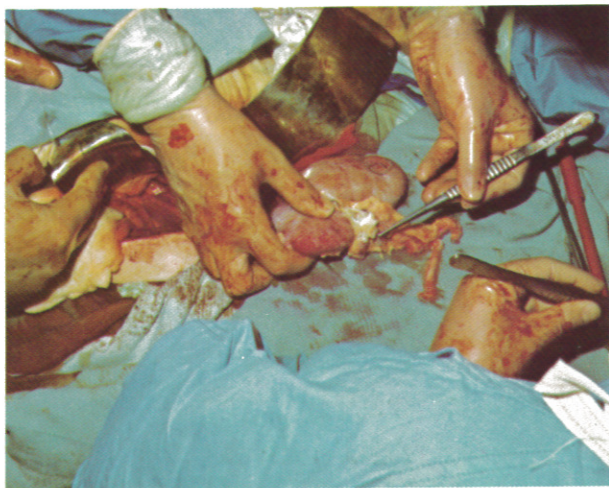
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REPLACEMENT OF KIDNEY AND REPAIRED ARTERY.
—The arterial anastomosis is complete.

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